Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41001

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDITH IRENE MOORE

2. Date of Death Month / Day / Year: Dec. 21, 1997

3. Time of Death: 3:00 p.m.

4e. Facility Name *(If not institution, give street and number)*: 502 N. Talbot St.

4b. City, Town, or Location of Death: St. Michaels

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 117-03-2648

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: NOV. 6, 1911

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Talbot

10c. City, Town or Location: St. Michaels

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 502 N. Talbot St.

10f. Zip Code: 21663

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 11; College (1-4or 5+): 4

16e. Decedent's Usuet Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: School Teacher

16b. Kind of Business/Industry: New York Public Schools

17. Father's Name *(First, Middle, Last)*: George Moore

18. Mother's Neme *(First, Middle, Meiden Surname)*: Isabelle Henderson

19a. Informent's Name/Relationship *(Type, Print)*: Wesley A. Waters Nephew

19b. Malling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 123 Kale Ave. Sterling, Virginia 20164

20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Thomas Memorial Cemetery

Date: Dec. 31, 1997

20c. Location - City or Town, Stete: St. Michaels, Md. 21663

21. Signature of Funeral Service Licensee: Harrison E Leonard

22. Neme end Address of Feclility: Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Md. 21663

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediete Cause (Finel disease or condition resulting in death): e. Cardiopulmonary arrest — 5 minutes

Due to (or es e consequence of):

Sequentially tist conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Lest:

b. Due to (or es a consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings evellable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and menner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier: Matthew J. Fisher MD

29c. License number: D0052251

29d. Date signed *(Month, Day, Yeer)*: 12/29/97.

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): Mathew Fisher M.D. 505 A Dutchmans Lane Easton, Maryland 21601

State Registrar

31. Dete filed *(Month, Day, Yeer)*: DEC 29 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41002

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Elizabeth S. Neely
2. Date of Death (Month, Day, Year): December 26, 1997
3. Time of Death: 10:45 PM
4a. Facility Name *(If not institution, give street and number)*: Sycamore Acres
4b. City, Town, or Location of Death: Derwood
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-01-6747
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 20, 1910
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: North Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13925 Bergenfield Drive
10f. Zip Code: 20878
10g. Citizen of What Country?: United States
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Secretary
16b. Kind of Business/Industry: Hospital
17. Father's Name *(First, Middle, Last)*: Charles A. Sparshott
18. Mother's Name *(First, Middle, Maiden Surname)*: Theresa Jones
19a. Informant's Name/Relationship *(Type, Print)*: Betty Jean Czarapata/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13925 Bergenfield Drive,N.Potomac, Maryland 20878
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park — Date: Dec. 30, 1997
20c. Location - City or Town, State: Rockville, Maryland
21. Signature of Funeral Service Licensee: Ray Faust M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Metastatic Squamous Carcinoma — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia, Osteoporosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☒ Other *(Specify)* Group Home

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert Millman
29c. License number: D13977
29d. Date signed *(Month, Day, Year)*: December 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert Millman, M.D. 9707 Medical Center Drive, Rockville, Maryland 20850

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 02 1998
Registrar's Signature: Judith Davidson-Ramsey

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41003

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: AM THI NGO

2. Date of Death — Month: December; Day: 24; Year: 1997

3. Time of Death: 10:00 A.M.

4a. Facility Name *(If not institution, give street and number)*: 14012 Broomall Lane

4b. City, Town, or Location of Death: Silver Spring,

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 586-48-4806

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Oct. 2, 1918

9. Birthplace *(State or Foreign Country)*: Viet Nam

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14012 Broomall Lane

10f. Zip Code: 20906

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* Vietnamese

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 0; College (1-4or 5+): 0

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: None

16b. Kind of Business/Industry: Not Applicable

17. Fethar's Neme *(First, Middle, Last)*: Unobtainable

18. Mother's Name *(First, Middle, Meiden Surneme)*: Unobtainable

19a. Informent's Name/Relationship *(Type, Print)*: Tan Ngo - Nephew

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 14012 Broomall Lane, Silver Spring, Maryland 20906

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Fort Lincoln Crematory

Dete: 12-29-97

20c. Location - City or Town, Stete: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Robert E. Hines

22. Nama and Address of Facility: Hines-Rinaldi Funeral Home, Inc. Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or conditions thet caused the death. Do not antar the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Possible cerebral hemorrhage

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immedieta ceuse. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest:

b. Hypertension

Due to (or es e consequence of):

c. congestive heart failure

Due to (or es e consequence of):

d. Hypertensive nephropathy

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I: Diabetes mellitus, type II

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Was cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Hema 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, streat, factory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier: Ton That Chieu

29c. License number: D 23429

29d. Date signed *(Month, Dey, Year)*: December 24, 1997

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): Ton That Chieu, M.D., 7505 New Hampshire Avenue, #310, Langley Park, Maryland 20783

State Registrar

31. Dete filed *(Month, Dey, Year)*: DEC 29 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

2

97-7500-031
B.K.S

MICHAEL OTT

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41004

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael Joseph Ott

2. Date of Death (Month, Day, Year): DEC. 26, 1997

3. Time of Death: 0407 AM

4a. Facility Name (If not institution, give street and number): MONTGOMERY GENERAL HOSPITAL E.R.

4b. City, Town, or Location of Death: OLNEY

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 219-68-5193

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 42 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 26, 1955

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Brookeville

10d. Inside City Limits: 1☐ Yes 2☐ No

10e. Street and Number: 21001 Georgia Avenue

10f. Zip Code: 20833

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 6

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Economist

16b. Kind of Business/Industry: Federal Reserve

17. Father's Name (First, Middle, Last): Ernest J. Ott

18. Mother's Name (First, Middle, Maiden Surname): Jean Marie Levock

19a. Informant's Name/Relationship (Type, Print): Joan Marie DeMetriou / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 N. Beaumont Avenue, Catonsville, Maryland 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery

Date: 12/30/97

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Hines-Rinaldi Funeral Home
11800 New Hampshire Avenue
Silver Spring, Maryland 20904

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

BMW

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year): 12/26/97

28b. Time of Injury: 0406 M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Driver wants accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET

28f. Location (Street and Number or Rural Route Number, City or Town, State): 21101 Georgia Ave 20904

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): DEC. 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. Aaron Locke, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997

32. Registrar's Signature

DHMH 16 Rev 6/95

97-7307-013
CMK
MARTIN H. OSWIECIMKA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41005

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martin Henry Oswiecimka

2. Date of Death (Month, Day, Year): DECEMBER 19, 1997

3. Time of Death: 0155AM

4a. Facility Name (If not institution, give street and number): NICODEMUS ROAD EAST OF HUNTERS CHOICE

4b. City, Town, or Location of Death: WESTMINSTER

4c. County of Death: CARROLL COUNTY

Funeral Director

5. Social Security Number: 214-17-3181

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 20 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 12, 1977

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 861 Sondie Drive

10f. Zip Code: 21157

10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 2

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): student

16b. Kind of Business/Industry: school

17. Father's Name (First, Middle, Last): Henryk E. Oswiecimka

18. Mother's Name (First, Middle, Maiden Surname): Edyta Irene Naphiwotzki

19a. Informant's Name/Relationship (Type, Print): Henryk E. Oswiecimka, father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 861 Sondie Drive, Westminster, MD 21157

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Deer Park Cemetery | Date: 12/23/97

20c. Location - City or Town, State: Smallwood, MD

21. Signature of Funeral Service Licensee: Katherine Pritts - Sweitzer

22. Name and Address of Facility: Pritts Funeral Home & Chapel
412 Washington Rd., Westminster, MD 21157

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): e. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest:

b. Due to (or es e consequence of):

c. Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Piece of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Othar (Specify) AT SCENE

27. Manner of Death: 1 [ ] Natural 2 [✓] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): 12/19/97

28b. Time of Injury: 0140 A M

28c. Injury at Work? 1 [ ] Yes 2 [✓] No

28d. Describe how injury occurred: motor vehicle collision

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify): street

28f. Location (Street and Number or Rural Route Number, City or Town, State): Nicodemus Ave Carroll Co, Md

29e. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: Dennis J. Chute MD

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): DECEMBER 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): DEC 23 1997

32. Registrar's Signature: Julie Strickler Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41006

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thomas Regis Pollins

2. Date of Death Month Day Year: December 25, 1997

3. Time of Death: 3:40 PM

4a. Facility Name *(If not institution, give street and number)*: 8057 Round Moon Circle

4b. City, Town, or Location of Death: Jessup

4c. County of Death: Howard

Funeral Director

5. Social Security Number: 176-14-1997

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 6, 1918

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Takoma Park

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1013 Heather Avenue

10f. Zip Code: 20912

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Postal Worker

16b. Kind of Business/Industry: U. S. Postal Service

17. Father's Name *(First, Middle, Last)*: Thomas M. Pollins

18. Mother's Name *(First, Middle, Maiden Surname)*: Ellen Kirk

19a. Informant's Name/Relationship *(Type, Print)*: Elizabeth M. Pollins / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1013 Heather Avenue, Takoma Park, Maryland 20912

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veteran's Cem.

Date: 12/30/97

20c. Location - City or Town, State: Crownsville, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Invasive Carcinoma of bladder - 3 years -

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of): b.

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Lung cancer -

Diabetes -

Stroke -

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D15374

29d. Date signed *(Month, Day, Year)*: 12/29/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Soto Udeh, M.D. 7525 Greenery Center, #209, Greenbelt, Maryland 20770

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 31 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41007

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Geneva Agnes Paolucci

2. Date of Death (Month, Day, Year): December 26, 1997

3. Time of Death: 11:17 AM

4a. Facility Name (If not institution, give street and number): 3925 Commander Drive

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-20-6522

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 19, 1924

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3925 Commander Drive

10f. Zip Code: 20782

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): William E. Bailey

18. Mother's Name (First, Middle, Maiden Surname): Helen P. Alexander

19a. Informant's Neme/Relationship (Type, Print): Felix D. Paolucci (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3925 Commander Drive, Hyattsville, MD 20782

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery

Date: 12/31/97

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: William L Byrd

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☒ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowtedge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signeture end title of certifier: Junette Gibbons MD

29c. License number: DC 11350

29d. Date signed (Month, Day, Year): December 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Junette Gibbons, M.D., 1140 Varnum Street, NE, Washington, DC 20017

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41008

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Emma Paulson

2. Date of Death: Month Dec. Day 29 Year 1997

3. Time of Death: 8:20 am

4a. Facility Name (If not institution, give street and number): Woodside Nursing Center

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578.88.8424

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 6, 1914

9. Birthplace (State or Foreign Country): Washington

Usual Residence of Decedent

10a. State: D.C.

10b. County:

10c. City, Town or Location: Washington D.C.

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3808 Fordham Road

10f. Zip Code: 20016

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): +4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Wilmot Danielson

18. Mother's Name (First, Middle, Maiden Surname): Sybil Lentnor

19a. Informant's Name/Relationship (Type, Print): Willima C. Paulson/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3801 Fordham Road, N.W. WDC 20016

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Comfort Crematory

Date: 12/31/97

20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: Ruth M. Peters

22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 WI AVE NW WDC 20016

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Cerebrovascular Accident	1 Week
Due to (or as a consequence of):	Diffuse Cerebrovascular Disease	3 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ruth Kevess-Cohen MD

29c. License number: D33159

29d. Date signed (Month, Day, Year): December 29 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ruth Kevess-Cohen, M. D. 8700 Georgia Ave. #400 Silver Spring, MD 20910

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997

32. Registrar's Signature: Julia Davidson-Rochelle

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 97 41009

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLARENCE EUGENE POHLE
2. Data of Death (Month, Day, Year): DECEMBER 28, 1997
3. Time of Death: 1:15 AM
4a. Facility Name *(If not institution, give street and number)*: Saint Joseph Medical Center
4b. City, Town, or Location of Death: Towson
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 173-01-7833
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Yaer: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: June 12, 1916
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Insida City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 4411 Chestnut Lane
10f. Zip Coda: 20853
10g. Citizen of Whet Country?: United States

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedant Evar in U.S. Armed Forcas? 1 [ ] Yas 2 [X] No If Yas, Giva Yaer or Detes:
13. Was Decedent of Hispanic Orlgin? (Specify Yes or No- If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No *Specify:*
14. Race - Americen Indian, Bleck, Whita, atc. *Specify:* White

15. Decedent's Education *(Spacify only highast grada compiatad)*: Elamantary/Secondary (0-12): 11 | Collaga (1-4or 5+):
16a. Decedent's Usuel Occupation *(Giva kind of work dona during most of working life. DO NOT usa ratired)*: Contractor
16b. Kind of Businass/Industry: Self-employed

17. Fathar's Name *(First, Middla, Last)*: Hubert Walker Pohle
18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Alice B. Sellers

19a. Informent's Name/Raiationship *(Type, Print)*: Michael Eugene Graham, DPM (nephew)
19b. Mailing Address *(Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 39 4th Street, #204, Laurel, MD 20707

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or other place)*: Chesapeake Crematory | Date: 12-29-97
20c. Location - City or Town, Stata: Beltsville, Maryland

21. Signeture of Funerel Sarvice Licensaa: ▶ Ellen W. Rapp
22. Nama and Address of Facility: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part1. Entar the disease, or complicetions that caesed the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only ona ceusa on aach lina.

Sequantially list conditions, if any, laeding to immadiata causa. Entar Undarlying Causa (Disaasa or injury thet initiated evants rasulting in death) Last

		Approximate Intarval Batween Onset and Death
Immediate Cause (Final disaase or condition rasulting in daath) a.	PULMONARY EDEMA	5 DAYS
Dua to (or as a consequence of): b.	AORTIC STENOSIS	YEARS
Dua to (or as a consaquance of): c.	CORONARY ARTERY DISEASE WITH BYPASS GRAFT	YEARS
Dua to (or es e consequence of): d.	METASTATIC CARCINOMA OF THE PROSTATE	YEARS

Part II. **Other significant conditions** contributing to death but not resulting in tha undarlying cause givan in Part I.

DIABETES MELLITUS

CAROTID ENDARTERECTOMY

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [X] No

25. Wes case rafarrad to madical examinar? 1 [ ] Yas 2 [X] No

26. Place of Death *(Chack only one)*: Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA | Othar: 4 [ ] Nursing Home 5 [ ] Rasidance 6 [ ] Othar *(Specify)*

27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Year)* | 28b. Tima of Injury | 28c. Injury at Work? 1 [ ] Yas 2 [ ] No | 28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Spacify)* | 28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowledga, daath occurred at the tima, data and place, and dua to tha cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and placa, and dua to tha cause(s) and mannar stetad.

29b. Signatura end title of certifier: ▶ Ceballos, MD
29c. Licansa number: D 25886
29d. Data signed *(Month, Day, Year)*: Dec. 28 · 1997

30. Name and eddrass of person who completed cause of death (Item 23a) (Type, Print): LILIA CEBALLOS, M.D. ST. JOSEPH HOSPITAL , Towson, Maryland

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 29 1997
32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

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To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41010

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSA LEE PRATT
2. Date of Death Month Dey Yeer: DEC. 12, 1997
3. Time of Death: 10:30PM
4a. Facility Name (If not institution, give street and number): 6525 ADAK STREET
4b. City, Town, or Location of Death: CAPITOL HEIGHTS
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 220-38-2704
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): APRIL 29, 1926
9. Birthplace (State or Foreign Country): MISSISSIPPI

Usual Residence of Decedent

10e. Stete: MD
10b. County: PRINCE GEORGES
10c. City, Town or Location: CAPITOL HEIGHTS
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 6525 ADAK STREET
10f. Zip Code: 20743
10g. Citizen of What Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 6TH | College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): DOMESTIC
16b. Kind of Business/Industry: PRIVATE FAMILY

17. Father's Name (First, Middle, Last): WILLIE BREWER
18. Mother's Name (First, Middle, Maiden Surname): IOLA BRITTON

19a. Informant's Name/Relationship (Type, Print): ROSE GOLDSTON-COEHINS
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 6525 ADAK ST., CAPITOL HEIGHTS, MD. 20743

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HARMONY MEMORIAL PARK | Dete: 12/18/97
20c. Location - City or Town, Stete: LANDOVER, MD.

21. Signature of Funerel Service Licensee: Terry O. Austin
22. Name and Address of Facility: AUSTIN ROYSTER FUNERAL HOME 3821 14TH ST. N.W. WASH, DC. 20011

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. | Approximete Intervel Between Onset and Death

Immediete Cause (Final disease or condition resulting in death): a. Carcinoma of The Esophagus — 1 yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated.

29b. Signature end title of certifier:
29c. License number: D19431
29d. Dete signed (Month, Dey, Year): 12/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANK RYAN, M.D., 11701 LIVINGSTON ROAD, FT. WASH, MD. 20744

State Registrar

31. Dete filed (Month, Day, Year): DEC 30 1997
32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41011

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUBEN LEON PARSON
2. Date of Death (Month, Dey, Yeer): DEC. 23, 1997
3. Time of Death: 12:30 PM.
4a. Facility Name (If not institution, give street and number): 3614 CEMETERY LANE
4b. City, Town, or Location of Death: WESTMINSTER
4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 230-22-9367
8. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthdey): 70 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG.17,1927
9. Birthplece (State or Foreign Country): VIRGINIA

Usuel Residence of Decedent

10a. State: MD.
10b. County: CARROLL
10c. City, Town or Location: WESTMINSTER
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 3614 CEMETERY LANE
10f. Zip Code: 21158
10g. Citizen of What Country: USA.

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: WW II
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 11 / College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): SHIP BUILDER
16b. Kind of Business/Industry: SHIP YARD

17. Fether's Neme (First, Middle, Last): CLIFFORD PAUL PARSON
18. Mother's Neme (First, Middle, Meiden Surneme): ALPHA WRAY

19a. Informent's Neme/Reletionship (Type, Print): EARNESTINE P. OLIVER-SISTER
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 3009 COURT DR., HOPEWELL, VA. 23860

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Plece of Disposition (Neme of cemetery, cremetory or other place): METRO CREMATORY
Dete: 12/29/97
20c. Location - City or Town, Stete: BALTIMORE, MD.

21. Signeture of Funerel Service Licensee: [signature]
22. Neme end Address of Fecility: FLETCHER FUNERAL HOME 254 E. MAIN ST., WESTMINSTER, MD. 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth)
a. Acute myocardial infarction — minutes

Due to (or es a consequence of):
b. Diabetes Mellitus — 10 years

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Last
Due to (or es a consequence of):
c. Hypertension — 10 years

Due to (or es a consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveilable prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one): Hospitel: 1☐ inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier: [signature], MD
29c. License number: D34298
29d. Dete signed (Month, Dey, Yeer): 12-29-97

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Robert Kass, M.D. 532 Baltimore Blvd Westminster, MD 21157

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 29 1997
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41012

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LuELLEN COVER PFOUTZ

2. Date of Death: Month 12 Day 23 Year 97

3. Time of Death: 4:45 AM

4a. Facility Name (If not institution, give street and number): Carroll Lutheran Village Health Care Ctr.

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 218-40-8273

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 1, 1915

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 200 St. Luke Circle

10f. Zip Code: 21158

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Carroll C. Cover

18. Mother's Name (First, Middle, Maiden Surname): Doral Diller

19a. Informant's Name/Relationship (Type, Print): Thomas D. Pfoutz/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2613 Stone Rd., Westminster, MD 21158

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Pipe Creek Cemetery

Date: 12/27

20c. Location - City or Town, State: Linwood, Maryland

21. Signature of Funeral Service Licensee: John M. Skiles M00534

22. Name and Address of Facility: Skiles Funeral Home, 136 E. Baltimore St., Taneytown, MD 21787

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Left Lower Lobe pneumonia — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dermatomyositis ± 10 years

Coronary heart disease

Diabetes mellitus Type 2

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. H. Carcore M.D.

29c. License number: D 906

29d. Date signed (Month, Day, Year): 12/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. H. CARCORE M.D. P.O. Box 1110 Union Bridge MD. 21791

State Registrar

31. Date filed (Month, Day, Year): DEC 24 1997

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41013

Joe Price, Joe Walters

Joe Price

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): JOE WEBSTER PRICE
2. Date of Death (Month, Day, Year): December 28, 1997
3. Time of Death: 2:35PM
4a. Facility Name (If not institution, give street and number): Memorial Hospital @ Easton
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot
5. Social Security Number: 577-60-1050
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-24-1915
9. Birthplace (State or Foreign Country): FREDERICK CO.

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: OXFORD
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10a. Street and Number: 105 BONFIELD AVENUE
10f. Zip Code: 21654
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify: XX
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ADMINISTRATOR
16b. Kind of Business/Industry: HOSPITAL
17. Father's Name (First, Middle, Last): CHARLES JASPER PRICE
18. Mother's Name (First, Middle, Maiden Surname): EDNA ADELIA NEIGHBOURS
19a. Informant's Name/Relationship (Type, Print): MARY REBECCA PRICE/WIFE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. BOX 146, OXFORD, MD 21654
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE CREMATION CENTER, LLC
Date: 12/29/97
20c. Location - City or Town, State: CHESTER, MD
21. Signature of Funeral Service Licensee: Maura E. Newnam
22. Name and Address of Facility: FELLOWS, HELFENBEIN, NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREET, EASTON, MD 21601

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	2 weeks
Due to (or as a consequence of): b.	Severe chronic obstructive lung disease.	years.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Primary biliary cirrhosis with ascites.	years.
Due to (or as a consequence of): d.	acute upon chronic renal failure	2 weeks

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

anemia

coronary artery disease.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D46020
29d. Date signed (Month, Day, Year): 12/29/97.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SYED I. ALI 506 IDLEWILD AVENUE, EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41014

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Virginia V.M. Richardson

2. Date of Death Month Day Year: December 29, 1997

3. Time of Death: 6:58 PM

4a. Facility Name (If not institution, give street and number): 10713 Barn Wood Lane

4b. City, Town, or Location of Death: Potomac

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 125-01-2552

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 30, 1909

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Potomac

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10713 Barn Wood Lane

10f. Zip Code: 20854

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4 or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): John O. VanMiddlesworth

18. Mother's Name (First, Middle, Maiden Surname): Euphemia J. Demarest

19a. Informant's Name/Relationship (Type, Print): Kenneth E. Richardson/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10713 Barn Wood Lane, Potomac, Maryland 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.

Date: Jan. 2, 1998

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Ray Faul M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

b. Generalized Arteriosclerotic Heart Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D07099

29d. Date signed (Month, Day, Year): December 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Francis C. Mayle, Jr., M.D. 10215 Fernwood Road, Bethesda, Maryland 20817

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998

32. Registrar's Signature

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41015

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Lest): MARGARET MAYO RING

2. Dete of Death — Month: DECEMBER Dey: 28, Yeer: 1997

3. Time of Deeth: 5:00 AM

4e. Feciility Neme (If not institution, give street end number): MANOR CARE - POTOMAC

4b. City, Town, or Location of Deeth: POTOMAC

4c. County of Deeth: MONTGOMERY

Funeral Director

5. Social Security Number: 719-16-3860

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Yeer): Feb. 14, 1912

9. Birthplece (Stete or Foreign Country): Wash. D.C.

Usuel Residence of Decedent

10e. Stete: Ga.

10b. County: Fulton

10c. City, Town or Location: Atlanta

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 771 Drewry Street N.E.

10f. Zip Code: 30306

10g. Citizen of Whet Country?: United States

11. Meritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, spacify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4or 5+): 4

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Education

17. Fether's Neme (First, Middle, Last): Robert Mayo Jr.

18. Mother's Neme (First, Middle, Meiden Surname): Julia Middleton

19e. Informent's Neme/Reletionship (Type, Print): Cintha Ring (Stepdaughter)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 771 Drewry St. N.E. Atlanta, Ga. 30306

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Metropolitan Crematory

Dete: Dec.29, 1997

20c. Location - City or Town, Stete: Alexandria, Va.

21. Signeture of Funerel Service Licensee: ▶ Curtis E. Day

22. Neme end Address of Feciility: DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions whet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in deeth): e. SEPSIS — 24 HOURS

Due to (or es e consequenca of):

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:

b. Due to (or es e consequenca of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: DEMENTIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one) — Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer):

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one) — 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, end due to the cause(s) end manner stated.

29b. Signeture end title of certifier: ▶ Michael J Grady

29c. License number: D38781

29d. Dete signed (Month, Dey, Yeer): December 29, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Michael J. Grady, M.D., 4910 Massachusetts Avenue, NW Suite #312 Washington, DC

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 30 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41016

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VIRGIL BENTON ROBINSON

2. Date of Death: Month 12 Day 24 Year 97

3. Time of Death: 8:30AM

4a. Facility Name (If not institution, give street and number): 1316 FENWICK LANE, #1308

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 307.38.5680

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 10, 1911

9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 1316 FENWICK LANE, #1308

10f. Zip Code: 20910

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): DOCTOR OF VETERINARY MEDICINE PATHOLOGIST/TOXICOLOGY

16b. Kind of Business/Industry:

17. Father's Name (First, Middle, Last): O.R. ROBINSON

18. Mother's Name (First, Middle, Maiden Surname): ANNIE WELDON

19a. Informant's Name/Relationship (Type, Print): Betty Arbuckle/Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 4348 Verplanck Place, N.W. Washington DC 20016

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): MT. COMFORT CREMATORY

Date: 12/29/97

20c. Location - City or Town, State: ALEXANDRIA, VA

21. Signeture of Funeral Service Licensee: ▶ Leah M. Peters

22. Name end Address of Facility: JOSEPH GAWLER'S SONS, INC. 5130 WISCONSIN AVE. NW, WASHINGTON, DC 20016

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset end Death
Immediate Cause (Final diseese or condition resulting in death)	a. Circulatory collapse	immediate
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Emotional and Physical Stress	2 weeks
	Due to (or as a consequence of):	
	c. Hypopituitarism	years
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Multiple Myeloma

Pacemaker in place for tachy-brady syndrome

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings evallable prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medicel examiner? 1 [X] Yes 2 [ ] No

26. Plece of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Yeer):

28b. Time of Injury: M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred:

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 [X] **Certifying Phyalcian:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, dete and plece, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: ▶ Ruth Keven-Cohen MD

29c. License number: D33159

29d. Date signed (Month, Day, Year): DECEMBER 26, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DR. RUTH COHEN 8700 GEORGIA AVE. #400, SILVER SPRING, MD 20910

State Registrar

31. Date filed (Month, Dey, Year): DEC 29 1997

32. Registrar's Signature: ▶ Julia Davidson-Randolph

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pegas 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantel Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41017

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Hilaire A. Robitaille	December 28, 1997	1:45 A.M.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-30-0013	1 X M 2 ☐ F	86 Yrs.			August 2, 1911	Massachusetts

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Takoma Park	1 X Yes 2 ☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
411 Lincoln Ave.	20912	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: white

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Electrical engineer	U.S. Government/GSA

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Arthur Robitaille	Yvonne Coulombe

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Donalda A. Robitaille/wife	411 Lincoln Ave. Takoma Park, MD 20912

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Gate of Heaven Cemetery	Dec. 31, 1997	Silver Spring, MD

21. Signature of Funeral Service Licensee: Donna M Neubert

22. Name and Address of Facility: Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, DC 20012

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic Heart Disease	years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Fractured Hip

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 X No	1 ☐ Yes 2 X No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 X Yes 2 ☐ No	Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 ☐ Natural 2 X Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	Dec 17 97	7 AM M	1 ☐ Yes 2 X No	Fell

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
at Home	411 Lincoln ave. Takoma Park Md

29a. Certifier (Check only one)
1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
John F. Tauber	D 08546	December 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
John F. Tauber, M.D. 8218 Wisconsin Ave. # 318 Bethesda, MD 20814

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 02 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41018

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: John H. Rogers

2. Date of Death Month Day Year: December 26, 1997

3. Time of Death: 1:00 P.M.

4a. Facility Name *(If not institution, give street and number)*: 1119 Kirklyn Ave.

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 220-44-1993

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 96 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: August 18, 1901

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Takoma Park

10d. Inside City Limits: ☒ Yes 2 ☐ No

10e. Street and Number: 1119 Kirklyn Ave.

10f. Zip Code: 20912

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanical engineer

16b. Kind of Business/Industry: Dept. of Navy

17. Father's Name *(First, Middle, Last)*: Alphonso Rogers

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth A. McDonald

19a. Informant's Name/Relationship *(Type, Print)*: John S. Rogers/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5607 37th Ave. Hyattsville, MD 20782

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Rock Creek Cemetery

Date: Dec. 29, 1997

20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: Bruce Meibaum

22. Name and Address of Facility: Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, DC 20012

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Congestive Heart failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

28. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Bruce Meibaum

29c. License number: D14404

29d. Date signed *(Month, Day, Year)*: December 27, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): CHARLES L. FRANKLIN JR 11120 NEW Hampshire Ave #408 Silver Spring Md 20904

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 02 1998

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

16

DHMH 16 Rev 6/95

RKD
97-7508-031
THOMAS
RONA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 97 41019

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Thomas Paul Rona
2. Date of Death Month Day Year: DECEMBER 27, 1997
3. Time of Death: 3:15P.M.
4a. Facility Name *(If not institution, give street and number)*: 8104 HAMILTON SPRING ROAD
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 017-28-0614
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Jan. 17, 1923
9. Birthplace *(State or Foreign Country)*: Hungary

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 8104 Hamilton Spring Road
10f. Zip Code: 20817
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Senior Scientist
16b. Kind of Business/Industry: Consulting

17. Father's Name *(First, Middle, Last)*: Edouard Rona
18. Mother's Name *(First, Middle, Maiden Surname)*: Irene Wirtz

19a. Informant's Name/Relationship *(Type, Print)*: Jinnett M. Rona/Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10370 Hampshire Green Ave., Fairfax, Virginia 22032

20a. Method of Disposition: 1 ☐ Buriel 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc. Date: Dec. 30, 1997
20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Ronny Funk M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive Arteriosclerotic

Due to (or as a consequence of):
b. Cardiovascular Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☒ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: DECEMBER 28, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LARON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 02 1998
32. Registrar's Signature: Judia Davidson-Randolph

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
Catherine	Elizabeth	Rovito	December 28, 1997	12:30 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Holy Cross Hospital	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
245-64-3594	1☐ M 2☒ F	55 Yrs.			Mar. 14, 1942	North Carolina

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1507 Crestline Road	20904	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4	Systems Integrator	Financial

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Hugh McFaddin	Frances Barnette

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
John Rovito / Husband	15-7 Crestline Road, Silver Spring, Maryland 20904

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Gate of Heaven Cemetery	12/31/97	Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Andrew S. Justice

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. METASTATIC NON SMALL CELL LUNG CANCER	6 months
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
R Mehan MD	D 33224	DECEMBER 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
R Mehan 50 W Edmonston Dr #303 Rockville MD 20852

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 31 1997	Julia Davidson-Randolph

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41021

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles G. Ruhl

2. Date of Death Month Day Year: December 24, 1997

3. Time of Death: 4:40PM

4a. Facility Name *(If not Institution, give street and number)*: 5502 Hoover Street

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-40-9635

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 11, 1912

9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5502 Hoover Street

10f. Zip Code: 20817

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4 or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Manager

16b. Kind of Business/Industry: Laboratory Transportation

17. Father's Name *(First, Middle, Last)*: George E. Ruhl

18. Mother's Name *(First, Middle, Maiden Surname)*: Carrie E. Dammann

19a. Informant's Name/Relationship *(Type, Print)*: Mary Aires Ruhl/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5502 Hoover Street, Bethesda, Maryland 20817

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Prospect Hill Cemetery

Date: December 27, 1997

20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: Barbara Jo McMullen Lawrence MO0831

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute MI

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Generalized Atherosclerotic disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Krysta Ambardar MD

29c. License number: D50026

29d. Date signed *(Month, Day, Year)*: 12/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 10215 Fernwood Rd Bethesda, MD. 20817

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41022

Physician /Medical Examiner

1. Decedent's Nema *(First, Middla, Last)*: DOUGLAS JOSEPH RYKHUS, JR.

2. Deta of Daath — Month: DECEMBER Dey: 27, Yeer: 1997

3. Time of Death: 1645

4e. Facility Neme *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 503-24-4494

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Yaar — Months: Deys: If Under 24 Hrs. — Hours: Min.:

8. Data of Birth *(Month, Dey, Year)*: September 9, 1930

9. Birthplaca *(State or Foreign Country)*: Minnesota

Usual Residence of Decedent

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Potomac

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 7905 Raphael Court

10f. Zip Code: 20854

10g. Citizen of Whet Country?: United States

11. Meritel Stetus: 1☐ Nevar Marriad 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Yaer or Datas: 1952-1954

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Attorney

16b. Kind of Businass/Industry: Civil Law

17. Fathar's Nema *(First, Middla, Last)*: Oscar Rykhus

18. Mother's Neme *(First, Middle, Maiden Surnema)*: Josephine Kosse

19e. Informent's Name/Relationship *(Type, Print)*: Nancy E. Rykhus/Wife

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7905 Raphael Court, Potomac, Maryland 20854

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Othar *(Specify)*

20b. Piece of Disposition *(Name of cemetary, crematory or other piece)*: Gate of Heaven Cemetery — Dete: December 31, 1997

20c. Location - City or Town, Stete: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: Michael E. Hagan M00846

22. Name end Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Final diseese or condition resulting in deeth)

e. Ventricular Arrythmia causing Cardiac Arrest (of Unkown cause) — 1 DAY

Due to (or es e consequenca of):

b. Lung Cancer — 3 months

Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

Due to (or es e consequenca of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending invastigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner as steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signature and title of certifier: MD.

29c. License number: D44157

29d. Data signad *(Month, Day, Year)*: DECEMBER 28, 1997

30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print): Ira Berger M.D. 809 Veirs Mill Road, Rockville, MD 20851

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 02 1998

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Blue

12/1/1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41023

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): William Martin Raftery

2. Date of Death — Month: Dec; Day: 28; Year: 1997

3. Time of Death: 3:33 AM

4a. Facility Name (If not institution, give street and number): Manor Care - Largo

4b. City, Town, or Location of Death: Largo

4c. County of Death: Prince George's

5. Social Security Number: 578-16-5263

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth (Month, Day, Year): Sept. 9, 1912

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Largo

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 600 Largo Road

10f. Zip Code: 20774

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): ; College (1-4 or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mail Clerk

16b. Kind of Business/Industry: Washington Post Newspaper

17. Father's Name (First, Middle, Last): Thomas Raftery

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Conway

19a. Informent's Name/Relationship (Type, Print): Eileen C. Langley (sister)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6 Fitzhugh Court, Silver Spring, MD 20906

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery

Date: 12/31/97

20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: Steven D Strand

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest — 30 minute

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Carcinoma of the Prostate with Bony Metastasis — several years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: chronic obstructive lung disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one) — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MKarim MD

29c. License number: D18895

29d. Date signed (Month, Day, Year): December 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MOBARAK KARIM, 7610 CARROLL AVENUE, TAKOMA PARK, MARYLAND

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997

32. Registrar's Signature: Judy Davidson-Hopkins

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 4 1024

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Max Ranhand

2. Date of Death: Month December Day 26 Year 1997

3. Time of Death: 1902

4a. Facility Name (If not institution, give street and number): Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 088-09-1412

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 12, 1908

9. Birthplace (State or Foreign Country): Roumania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 7700 Cherry Lane

10f. Zip Code: 20707

10g. Citizen of What Country? United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Linotype Operator

16b. Kind of Business/Industry: Newspaper

17. Father's Name (First, Middle, Last): James Ranhand

18. Mother's Name (First, Middle, Maiden Surname): Clara (Unknown)

19a. Informant's Name/Relationship (Type, Print): Jon Ranhand (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 Barrington Fair, Rockville, Maryland 20850

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Riverside Cemetery

Date: 12-28-97

20c. Location - City or Town, State: Saddle Brook, N.Y.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Danzansky-Goldberg Mem. Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. Abdominal Aortic Aneurysm — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ A. Flores M.D.

29c. License number: D36716

29d. Date signed (Month, Day, Year): December 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Andrew Kundrat 8317 Cherry Lane, Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997

32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41025

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles L. Roome
2. Date of Death Month Day Year: December 28 1997
3. Time of Death: 12:30 am
4a. Facility Name (If not institution, give street and number): Harmony Hall
4b. City, Town, or Location of Death: Columbia
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 577-01-2090
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 18, 1905
9. Birthplace (State or Foreign Country): New Jersey

Usual Residance of Decedant

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1 ☐ Yas 2 ☒ No
10e. Street and Number: 6336 Cedar Lane
10f. Zip Code: 21044
10g. Citizen of What Country?: United States

11. Maritel Stetus: 1 ☐ Nevar Married 2 ☐ Merried 3 ☒ Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yes, Give Yaer or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indien, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grada completad): Elemantary/Secondary (0-12) | Collega (1-4or 5+): 2
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired): Plant Foreman
16b. Kind ot Businass/Industry: Telephone Company

17. Fathar'e Name (First, Middla, Last): Harry Roome
18. Mothar's Nama (First, Middla, Maidan Surneme): Emma Lawrence

19a. Informant's Name/Raiationship (Type, Print): Nancy Whitelock/Daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stata, Zip Code): 10017 Hackberry Lane Columbia, Maryland 21046

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cremetion 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify)
20b. Place of Disposition (Nama of cemetary, crematory or othar place): Fort Lincoln Cemetery
Data: 1-2-98
20c. Location - City or Town, Stete: Bladensburg, MD

21. Signeture of Funeral Sarvice Licensee: ▶ Sharon A. Collins-Witzke
22. Nama and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused tha death. Do not entar the moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona cause on aach line. Approximate Intarval Batween Onset and Daath

Immediate Causa (Final disaasa or condition resulting in daath): a. Pneumonia — Days
Dua to (or as a consequence of): b. Arteriosclerosis
Sequantially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disaasa or Injury that initiated evants rasulting in death) Last
Dua to (or as s consequance of): c.
Dua to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying causa given in Part I.: myelodysplastic Syndrome

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was casa raferred to medical examinar? 1 ☐ Yas 2 ☒ No

26. Place ot Death (Check only ona): Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA | Othar: 4 ☒ Nursing Homa 5 ☐ Residence 6 ☐ Othar (Specify)

27. Mannar of Death: 1 ☒ Natural 2 ☐ Accidant 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Pending investigation 6 ☐ Could not be datarmined
28a. Date ot Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 ☐ Yas 2 ☐ No
28d. Describe how injury occurred
28a. Place of Injury - At homa, ferm, street, tactory, office buiiding, atc. (Specify)
28t. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifiar (Check only one): 1 ☒ **Certifying Physician:** To tha best of my knowledga, death occurred at the tima, data and place, and dua to tha causa(s) and mannar as ststed. 2 ☐ **Medical Examiner:** On tha basis ot axamination and/or investigetion, in my opinion, deeth occurred et the tima, deta and place, and dua to tha causa(s) and mannar statad.

29b. Signature and title of certifier: ▶
29c. License number: D22852
29d. Date signed (Month, Day, Year): December 29, 1997

30. Name and eddrass of person who complatad causa of death (Item 23e) (Type, Print): Jeremy R. Levine, DO 11055 Little Patuxent Pky, Columbia MD

State Registrar

31. Data filed (Month, Day, Year): DEC 29 1997
32. Registrar's Signature: Julia Strickler Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

25

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41026

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Katherine M. Renshaw

2. Dete of Deeth: Month Dec Day 30 Year 1997

3. Time of Deeth: 3:18 PM

4e. Facility Neme (If not institution, give street and number): Genesis ElderCare - The Pines

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Sociel Security Number: 213-22-6509

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Yeer): JULY 4, 1905

9. Birthpleca (Stete or Foreign Country): MARYLAND

Usuel Residence of Decedent

10e. Stete: MD

10b. County: TALBOT

10c. City, Town or Location: EASTON

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 401 DUTCHMAN'S LANE

10f. Zip Code: 21601

10g. Citizen of Whet Country?: USA

11. Merital Status: 1☐ Nevar Marriad 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Yaar or Datas:

13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - Americen Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Educetion (Specify only highest grade completed): Elementery/Secondary (0-12): 11; College (1-4or 5+): 2

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWN HOME

17. Fether's Nema (First, Middle, Last): ALFRED B. MASON

18. Mother's Name (First, Middle, Maiden Surneme): EMILY THOMPSON

19a. Informent's Name/Reletionship (Type, Print): DIANE R. BISANAR

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8597 WHEATLANDS ROAD, EASTON, MD 21601

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): CHESAPEAKE CREMATION CENTER, L.L.C.

Dete: 12-31

20c. Location - City or Town, State: CHESTER, MD

21. Signeture of Funerel Service Licensee: M. L. Newnam III CFSP

22. Neme end Address of Facility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 21601

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part1. Enter the disaesa, or complicetions thet ceused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Death

Immediete Ceusa (Finel diseesa or condition resulting in death): e. BREAST CARCINOMA — 4 YEARS

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Disaase or injury thet initieted events resulting in deeth) Lest:

b.

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ENDOMETRIAL CARCINOMA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings eveileble prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☑ No

26. Pleca of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Sulcida 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office buiiding, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) and menner es steted. 2☐ **Medicat Examiner:** On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) and manner steted.

29b. Signeture and title of certifier: MD

29c. License number: D23962

29d. Dete signed (Month, Dey, Yeer): 12.30.97

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): SCOTT D. FRIEDMAN MD 403 MARVEL COURT EASTON, MD 21601

State Registrar

31. Date filed (Month, Day, Yaar): JAN 02 1998

32. Registrer's Signeture: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

ALFRED

DIANE R. BIS.

X

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41027

PEARLY RODGERS

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Pearly Rogers
2. Date of Death: Month Dec. Day 30 Year 1997
3. Time of Death: 4:00 a
4a. Facility Name (If not institution, give street and number): Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 237-36-6256
6. Sex: 1☐ M 2☐ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 7,1904
9. Birthplace (State or Foreign Country): Wash. D.C.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Caroline
10c. City, Town or Location: Preston
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: P. O. Box 286
10f. Zip Code: 21655
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 6th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Poultry Plant

17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): Laura Mae Rogers
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. Box 286, Preston MD 21655

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Capitol Crematory
Date: 12/30/97
20c. Location - City or Town, State: Dover DE

21. Signature of Funeral Service Licensee: John A. Prince
22. Name and Address of Facility: Bennie Smith Funeral Home, 426 Dover St. Easton MD 21601

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Urosepsis — Due to (or as a consequence of): — 2 Days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James B. Reed MD
29c. License number: D31376
29d. Date Signed (Month, Day, Year): 12/30/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998
32. Registrar's Signature: Julia Davidson-Rodgers

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41028

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: WINIFRED VIOLA RITTER

2. Dete of Death Month / Dey / Yeer: DEC. 25, 1997

3. Time of Death: 6:00 AM

4e. Facility Neme *(If not institution, give street and number)*: 403 GLEBE ROAD

4b. City, Town, or Location of Death: EASTON

4c. County of Deeth: TALBOT

Funerai Director

5. Social Security Number: 197-09-8273

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Yeer)*: JAN.1,1921

9. Birthplace *(Stete or Foreign Country)*: PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD

10b. County: TALBOT

10c. City, Town or Location: EASTON

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street end Number: 403 GLEBE ROAD

10f. Zip Code: 21601

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes ☒ No *Specify:*

14. Rece - American Indien, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondary (0-12): 11; College (1-4or 5+): 0

16a. Decedent's Usuel Occupetion *(Giva kind of work done during most of working life. DO NOT use retired)*: SALES PERSON

16b. Kind of Business/Industry: DEPARTMENT STORE

17. Fether's Neme *(First, Middle, Last)*: URHIA DAVID

18. Mother's Neme *(First, Middle, Maiden Sumeme)*: ANNIE GAGHEN

19a. Informant's Name/Reletionship *(Type, Print)*: ROBERT J. RITTER

19b. Mailing Address *(Street end Number or Rurel Routa Number, City or Town, Stete, Zip Code)*: 403 GLEBE ROAD, EASTON, MD 21601

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: CHESAPEAKE CREMATION CENTER, L.L.C.

Deta

20c. Location - City or Town, Stete: CHESTER, MD

21. Signeture of Funerel Service Licensee: Mann G Mann IV

22. Neme end Address of Feclility: FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 200 S. HARRISON ST., EASTON, MD 21601

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Congestive Heart FAILURE — 1 yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Atherosclerotic Coronary Artery Disease — 10 yr

Due to (or as a consequence of):

c. Diabetes Mellitus II — 20 yr

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard A. Burgoyne MD

29c. License number: D42816

29d. Date signed *(Month, Day, Year)*: 12/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard A. Burgoyne 607 Dutchmans Lane EASTON MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41029

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lydia Roach

2. Date of Death (Month, Day, Year): Dec 30 1997

3. Time of Death: 9:20 PM

4a. Facility Name (If not institution, give street and number): Genesis ElderCare - The Pines

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 213-24-1238

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/17/1926

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Talbot

10c. City, Town or Location: Trappe

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4727 Old Trappe Road

10f. Zip Code: 21673

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Presser

16b. Kind of Business/Industry: Sewing Factory

17. Father's Name (First, Middle, Last): Samuel A. Gibson

18. Mother's Name (First, Middle, Maiden Surname): Harriet Louise Scott

19a. Informant's Name/Relationship (Type, Print): Doulas Gibson (brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 704 North St.,Milford,De.19963

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Federal Hill Cemetery

Date: 1/03/98

20c. Location - City or Town, State: Federalsburg,Maryland

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Name and Address of Facility: Bennie smith funeral Home P.O.Box 1687,Easton, Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. progressive cerebellar dysfunction — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

arthritis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D25750

29d. Date signed (Month, Day, Year): 12/31/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT B. SANCHEZ 308 Idlewild Ave Easton MD 21601

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amend #8, 1/2/98, BMW, Montg.Co

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41030

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Wayne Smithers
2. Date of Death Month Day Yeer: December 23, 1997
3. Time of Death: 4:30 pm
4a. Facility Name (If not institution, give street and number): 4 Wessex Road
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-42-2203
6. Sex: [X] 1 M [ ] 2 F
7. Age (In yrs. last birthday): 69 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): ~~December 20, 1920~~ October 20, 1928
9. Birthplece (State or Foreign Country): Michigan

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: [ ] 1 Yes [X] 2 No
10e. Street end Number: 4 Wessex Road
10f. Zip Code: 20910
10g. Citizen of What Country?: U.S.A.

11. Marital Stetus: [X] 1 Never Merried [ ] 2 Married [ ] 3 Widowed [ ] 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? [X] 1 Yes [ ] 2 No — If Yes, Give Year or Dates: 1950-52
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): [ ] 1 Yes [X] 2 No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): cutter/binder
16b. Kind of Business/Industry: print Shop

17. Father's Neme (First, Middle, Last): Lawrence E. Smithers
18. Mother's Neme (First, Middle, Malden Surneme): Nina Burgess

19a. Informent's Neme/Reletionship (Type, Print): Beverly S. Geibel/sister
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 3505 Fullerton St. Beltsville, MD 20705

20a. Method of Disposition: [X] 1 Buriel [ ] 2 Cremetion [ ] 3 Removel from State [ ] 4 Donetion [ ] 5 Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other place): Rock Creek Cemetery
Date: Dec. 30, 1997
20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: Bryan J. Meehan
22. Neme end Address of Fecility: Takoma Funeral Home, Inc. 254 Carroll St. NW Washington, DC 20012

BMW

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet ceused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Cardiac arrythmia — 5 mins
Due to (or es e consequence of):
Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Emphysema

23b. Did tobacco use contribute to the cause of death? [X] 1 Yes [ ] 2 No [ ] 3 Probably [ ] 4 Unknown

24a. Wes en eutopsy performed? [ ] 1 Yes [X] 2 No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? [ ] 1 Yes [X] 2 No

25. Wes cese referred to medicel exeminer? [X] 1 Yes [ ] 2 No

26. Piece of Deeth (Check only one): Hospitel: [ ] 1 Inpetient [ ] 2 ER/Outpetient [ ] 3 DOA; Other: [ ] 4 Nursing Home [X] 5 Residence [ ] 8 Other (Specify)

27. Menner of Deeth: [X] Neturel [ ] 2 Accident [ ] 3 Suicide [ ] 4 Homicide [ ] 5 Pending investigetion [ ] 6 Could not be determined

28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? [ ] 1 Yes [ ] 2 No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): [ ] 1 Certifying Phyeician: To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the cause(s) and menner as stated. [X] 2 Medicel Exeminer: On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred at the time, dete end piece, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: John F Tauber
29c. License number: D00546
29d. Dete signed (Month, Dey, Yeer): December 24, 1997

30. Neme end address of person who completed ceuse of deeth (Item 23e) (Type, Print): John F. Tauber, M.D. 8218 Wisconsin Ave. #318 Bethesda, MD 20814

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 02 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend #12,#18,#20b, 1/7/98, BMW,Montg.Co.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41031

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sol Stieber
2. Date of Death (Month, Day, Year): December 24,1997
3. Time of Death: 5:18 am
4a. Facility Name (If not institution, give street and number): Suburban Hospital
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 149-01-1825
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec.13,1915
9. Birthplace (State or Foreign Country): Hungary

Usual Residance of Decedent

10a. State: FL
10b. County: Broward
10c. City, Town or Location: Lauderhill
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 3301 Spanish Moss Terrace
10f. Zip Code: 33319
10g. Citizan of Whet Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? ~~1 [ ] Yes~~ 2 [X] No ~~WWII~~ If Yes, Give Yeer or Detes:
13. Wes Dacedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indien, Bleck, White, etc.: Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementary/Sacondary (0-12): / Collega (1-4or 5+): 4
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: U.S. Navy

17. Father's Name (First, Middle, Last): Rev. Israel Stieber
18. Mother's Neme (First, Middle, Maiden Sumeme): Clara ~~Scherling~~ Schechter

19a. Informant's Neme/Reletionship (Type, Print): Jane Stieber/Daughter
19b. Meiling Address (Straet end Number or Rurel Route Number, City or Town, State, Zip Code): 2555 Pennsylvania Ave.N.W.Washington, D.C. 20037

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Othar (Specify)
20b. Piece of Disposition (Name of cemetery, cremetory or other piece): B'Nai Abraham ~~Cemetery~~ Memorial Park
Dete: 12/26/97
20c. Location - City or Town, State: Union, N.J.

21. Signetura of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Ives-Pearson Funeral Homes 2847 Wilson Blvd. Arlington, VA 22201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the daeth. Do not enter the mode of dying, such as cardiac or respiretory errast, shock, or heert failure. List only one ceuse on aech line.

Approximeta Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. Coronary Artery Disease — 17 years

Sequentially list conditions, if eny, leading to immediete causa. Enter Underlying Causa (Disease or injury thet initieted events resulting in daath) Lest
b. Due to (or es e consequance of):
c. Due to (or as a consequence of):
d. Due to (or es e consequence of):

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Cerebral hypoxia secondary to cardiac arrest 9/30/97
Pneumonitis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings aveileble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Menner of Death: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding investigation 6 [ ] Could not be determined
28a. Dete of Injury (Month, Day Year):
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred:
28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify):
28f. Location (Street end Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, daath occurred at the time, date end place, end due to the causa(s) and manner es stated. 2 [ ] **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at tha time, date and place, end due to the causa(s) end menner stetad.

29b. Signetura end title of certifier: Douglas R. Rosing, MD
29c. License number: D32193
29d. Deta signed (Month, Dey, Year): 12/24/97

30. Nema and eddress of person who completed causa of deeth (Item 23e) (Type, Print): Douglas R. Rosing,M.D. 6410 Rockledge Dr.#200 Bethesda, MD 20817

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Shew

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41032

Physician /Medical Examiner

1. Decadant's Name *(First, Middle, Last)*: Beniamino Silvio Lorenzo Sacuto

2. Data of Death Month Day Year: December 25, 1997

3. Tima of Death: 4:45 AM

4a. Facility Nama *(If not institution, giva street and number)*: 3330 North Leisure World Boulevard #414

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 104-32-8762

6. Sex: 1☒ M 2☐ F

7. Aga *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: June 1, 1913

9. Birthplece *(Stata or Foraign Country)*: Tunisia

Usual Residanca of Dacedant

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3330 North Leisure World Boulevard #414

10f. Zip Coda: 20906

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐ Nevar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Year or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- if Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☒ Yas 2☐ No *Specify:* Spanish and Portuguese

14. Rece - Amarican Indian, Black, Whita, etc. *Specify:* White

15. Dacadant's Education *(Spacify only highast grade completed)*: Elamentary/Secondary (0-12): ; College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Physician

16b. Kind of Businass/Industry: Private Practice

17. Fathar's Neme *(First, Middla, Last)*: Salomone Felice

18. Mothar's Neme *(First, Middle, Malden Sumame)*: Juliette Esther Valensi

19a. Informant's Name/Ralationship *(Type, Print)*: Enrica Sacuto (wife)

19b. Mailing Address *(Street and Number or Rural Routa Number, Clty or Town, Stata, Zip Coda)*: 3330 North Leisure World Boulevard, #414, Silver Spring, MD 20906

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory

Data: 12-26-97

20c. Location - City or Town, Stata: Beltsville, Maryland

21. Signatura of Funerel Sarvica Licansaa: Carol a Dehn

22. Nama and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Entar tha disaasa, or complications that causad tha daath. Do not enter tha moda of dying, such es cardiac or raspiratory arrast, shock, or heart failure. List only ona causa on aach lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in deeth)

a. Colon Cancer — Three Years

Dua to (or as a consequance of):

Sequantially list conditions, if any, laading to immediate causa. Entar Underlying Causa (Disaase or injury that initiated avants rasulting in daeth) Last

b.

Dua to (or as a consequance of):

c.

Dua to (or as a consequence of):

d.

Part II. **Othar significant conditions** contributing to daath but not rasulting in tha undarlying causa given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Wes an autopsy performad? 1☐ Yas 2☒ No

24b. Were autopsy findings availabla prior to compiation of cause of death? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only ona)*: Hospitei: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Home 5☒ Rasidence 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28e. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, etc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Cartifying Physician:** To the best of my knowladga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examinetion and/or invastigetion, in my opinion, daath occurred at tha tima, data and placa, and due to the cause(s) and menner stated.

29b. Signatura and titia of cartifiar: M Miller, MD

29c. Licansa number: D33686

29d. Dete signed *(Month, Dey, Year)*: December 29, 1997

30. Nama and aodrass of person who completed cause of deeth (Item 23e) (Type, Print): Kenneth Miller, MD 18111 Prince Philip Dr. Olney, MD 208

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

State Registrar

31. Data filad *(Month, Day, Yaar)*: DEC 29 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41033

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEAH SCHIFF
2. Date of Death (Month, Day, Year): DECEMBER 11, 1997
3. Time of Death: 11:15AM
4a. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: TAKOMA PARK
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 051-30-4756
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12/20/1918
9. Birthplace (State or Foreign Country): NEW YORK

Usual Residance of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1400 FENWICK LANE APT#306
10f. Zip Code: 20910
10g. Citizen of What Country: USA

11. Maritai Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Dacedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:
14. Raca - American Indian, Black, Whita, atc. Specify: WHITE

15. Decedent's Education (Spacify only highast grada compiatad): Elamentary/Secondary (0-12): 12TH | Collaga (1-4or 5+):
16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratirad): CLERK
16b. Kind of Businass/Industry: DRY CLEANERS

17. Father's Name (First, Middle, Last): SAMUEL FOSS
18. Mothar's Nama (First, Middle, Maidan Sumama): MARTHA SWITHAUER

19a. Informant's Name/Relationship (Type, Print): KAREN E. SCHIFF DAUGHTER
19b. Mailing Address (Straat and Number or Rural Route Number, City or Town, Stata, Zip Code): 7314 REDDFIELD CT. FALLS CHURCH, VA. 22043

20a. Mathod of Disposition: 1☐ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☒ Donation 5☐ Othar (Specify)
20b. Placa of Disposition (Nama of camatary, cramatory or othar placa): GEORGETOWN MED SCH. Data: 12/11/97
20c. Location - City or Town, Stata: WASHINGTON, D.C.

21. Signatura of Funaral Sarvica Licansaa: Henry L. Austin
22. Nama and Address of Facility: AUSTIN ROYSTER FUNERAL HOME 3821 14TH ST. N.W. WASH, DC. 20011

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, of complications that causad tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

		Approximata Intarval Batwaan Onsat and Death
Immadiata Causa (Final disaasa or condition resulting in daath) a.	Cardiopulmary arrest	10 min
Dua to (or as a consaquanca of): b.	Sepsis	3 days
Sequantially list conditions, if any, laading to Immadiata cause. Enter Undarlying Causa (Disaasa or injury thet initiatad avants rasulting in daath) Last — Dua to (or as a consaquanca of): c.	Shock	4 days
d.	Gangarene bowel	4 days

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

Cardiomyopathy
Small bowel obstruction
Dehydration

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Placa of Daath (Chack only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined
28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To tha bast of my knowladga, daath occurrad at the time, data and placa, and dua to the causa(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to the causa(s) and mannar stated.

29b. Signatura and title of cartifiar: [signature] MD
29c. License number: D46354
29d. Data signed (Month, Day, Year): 12/11/97

30. Nama and address of parson who completed causa of daath (Item 23a) (Type, Print): Dong S. Hwang MD 7610 Carroll Ave, Takoma Park, MD 20912

State Registrar

31. Data filed (Month, Day, Year): DEC 30 1997
32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

#29d F.H. had distinctly Reading Family of deceased

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41034

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARTHA BREUER SCHNEIDER

2. Date of Death Month Day Year: DECEMBER 30, 1997

3. Time of Death: 7:15 am

4a. Facility Name (If not institution, give street and number): 4450 South Park Ave., Apt. 404

4b. City, Town, or Location of Death: Chevy Chase

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577 26 0092

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept 16 1905

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Chevy Chase

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4450 South Park Ave., Apt. 404

10f. Zip Code: 20815

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home-maker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Lest): Samuel Breuer

18. Mothar's Name (First, Middle, Maiden Sumame): Emma Leindorf

19a. Informant's Name/Relationship (Type, Print): Sandra Lebowitz /daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 English Ivy Court, Rockville, Md. 20854

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt.Comfort, Alexandria Va

Date: 12/31/97

20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: Sean M Peters

22. Name and Address of Facility: Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave. N.W. Washington, D.C. 20016

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or haart failure. List only one cause on each line.

Approximate Interval Between Onset end Deeth

Immediate Cause (Final disease or condition resulting in death): a. Sub-Arachnoid Fluid — weeks

Due to (or as a consaquence of): Hypertension — years

Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as e consequence of):

d.

Part II. **Other signfficant conditions** contributing to death but not resulting in tha underlying ceuse given in Part I.

23b. **Did tobacco uae contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturai 2☐ Accident 3☐ Sulcide 4☐ Homlcide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one): 1☒ **Certifying Phyaician**: To tha bast of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and mannar as stated. 2☐ **Medicat Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D 39456

29d. Date signed (Month, Day, Year): 12/30/97

30. Name and address of person who complated ceuse of death (Item 23a) (Type, Print): Lela McConnell, M.D. #2 Wisconsin Circle, Chevy Chase, Md. 20815

State Registrar

31. Date filed (Month, Day, Yaar): DEC 31 1997

32. Registrar's Signature: Julia Davidson-Randolph

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41035

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Aaron Michael Schreiber

2. Date of Death Month Dey Year: December 29, 1997

3. Time of Death: 8:20 PM

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 056-10-3451

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: April 13,1911

9. Birthplece *(State or Foreign Country)*: New York

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 302 Winding Rose Dr.

10f. Zip Code: 20850

10g. Citizen of What Country?: United States

11. Meritel Stetus: 1☐Never Merried 2☐Merried 3☒Widowed 4☐Divorcad

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Postal Clerk

16b. Kind of Business/Industry: U.S. Government

17. Father's Name *(First, Middle, Last)*: Benjamin Schreiber

18. Mother's Name *(First, Middle, Meiden Sumame)*: Rebecca Metzger

19a. Informent's Name/Relationship *(Type, Print)*: Albert Schreiber (Son)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 302 Winding Rose Dr., Rockville, Maryland 20850

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from Stata 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetary, cremetory or other pleca)*: Judean Memorial Gdns.

Dete: 1-2-98

20c. Location - City or Town, Stete: Olney, Maryland

21. Signeture of Funeral Service Licensee: By [illegible]

22. Neme and Address of Facility: Danzansky-Goldberg Mem. Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852

BRW

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or compltcations thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel disease or condition resulting in deeth)
e. ASPIRATION PNEUMONIA — 24hrs

Due to (or es e consequenca of):
b. sepsis — 24hrs

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Lest
Due to (or as a consequenca of):
c. MULTINFARCT DEMENTIA — YEARS

Due to (or as a consequenca of):
d.

Part II. **Other signiflcant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Wes en eutopsy pertormed? 1☐Yes 2☒No

24b. Were eutopsy findings availeble prior to completion of cause of deeth? 1☐Yes 2☐No

25. Was case referred to medical exeminer? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpetient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Steta)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end placa, and due to the cause(s) end menner as stated. 2☐**Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred et the tima, date end piaca, and dua to the ceusa(s) end menner steted.

29b. Signeture and title of certifier: [illegible] M.D.

29c. Licensa number: D37024

29d. Data signed *(Month, Day, Year)*: December 29, 1997

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): DAVID G. SHOUR, M.D. 9901 Medical Center Drive Rockville Md. 20850

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 02 1998

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41036

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LAURENCE E SEIBEL
2. Date of Death (Month, Day, Year): DECEMBER 29, 1997
3. Time of Death: 1:52 AM
4a. Facility Name (If not institution, give street and number): 5523 UPPINGHAM STREET
4b. City, Town, or Location of Death: CHEVY CHASE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 123-09-0031
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 8, 1918
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 5523 Uppingham St.
10f. Zip Code: 20815
10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Attorney
16b. Kind of Business/Industry: Law

17. Father's Name (First, Middle, Last): Irving Seibel
18. Mother's Name (First, Middle, Maiden Surname): Estelle Lichter

19a. Informant's Name/Relationship (Type, Print): Hilda T. Seibel (Wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5523 Uppingham St., CHevy Chase, MD 20815

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Comfort Crematory
Date: 1-2-98
20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cardiomyopathy — Years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Coronary Artery Disease — Years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Ventricular Arrhythmia

Asthma

Bronchiectasis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: D. Scott Cohen MD
29c. License number: Maryland D42051
29d. Date signed (Month, Day, Year): DECEMBER 30, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. D. SCOTT COHEN, 5454 WISCONSIN AVENUE, SUITE #1125, CHEVY CHASE, MARYLAND 20815

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998
32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41037

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALVIN M. SEIDEL

2. Date of Death: Month 12 Day 25 Year 97

3. Time of Death: 9:00 PM

4e. Facility Name (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-40-1750

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 25, 1932

9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 9806 Hillridge Dr.

10f. Zip Code: 20895

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: Korea

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Wine Retailer

16b. Kind of Business/Industry: Self-Employed

17. Father's Name (First, Middle, Last): Jack Louis Seidel

18. Mother's Name (First, Middle, Maiden Surname): Pauline Seigel

19a. Informant's Name/Relationship (Type, Print): Barbara Seidel/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9806 Hillridge Dr. Kensington, MD 20895

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): King David Mem. Gdns.

Date: 12/28/97

20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ives-Pearson Funeral Homes, 2847 Wilson Blvd. Arlington, VA 22201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. BASILAR ARTERY Thrombosis — 5 days

Due to (or as a consequence of):

b. CEREBRAL VASCULAR Atherosclerosis — 2 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. DIABETES MELLITUS INSULIN DEPENDANT — 25 yrs

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Morton W. Shapiro

29c. License number: D10242

29d. Date signed (Month, Day, Year): 12/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MORTON W. SHAPIRO, M.D., 5225 Pooks Hill Road Bethesda Md. 20814

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997

32. Registrar's Signature: Julia Davidson-Rondelle

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41038

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY HARRIS SHOOK

2. Date of Death (Month, Day, Year): Dec. 25, 1997

3. Time of Death: 4:45 pm

4a. Facility Name (If not institution, give street end number): 9909 Summit Ave.

4b. City, Town, or Location of Death: Kensington

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-34-5877

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept.12, 1936

9. Birthplace (State or Foreign Country): Washington DC

Usual Residence of Decedent

10a. State: MD.

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 9909 Summit Ave.

10f. Zip Code: 20895

10g. Citizen of Whet Country?: U.S.A.

11. Meritai Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: white

15. Decedent's Edcetion (Specify only highest grede completed)

Elementery/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Manager/Officer

16b. Kind of Business/Industry: US Research Grants

17. Fether's Name (First, Middle, Last): Thomas H. Harris

18. Mother's Name (First, Middle, Maiden Surname): Mary Gawler

19a. Informant's Name/Reletionship (Type, Print): J.A. Shook Jr.

19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 9909 Summit Ave Kensington, MD 20895

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): Mt. Comfort Crematory

Date: 12/29/97

20c. Location - City or Town, Stete: Alexandria, VA.

21. Signature of Funeral Service Licensee: Leah M. Peters

22. Name and Address of Fecility: Joseph Gawlers Sons Inc. 5130 Wisconsin Ave. NW Washington DC 20016

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediete Ceuse (Final disease or condition resulting in death)

a. Glioblastoma — 1 year

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to Immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Phlebitis

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings aveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner es stated. 2☐ Medicel Exeminer: On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Daniel Rosenblum MD

29c. License number: D04766

29d. Date signed (Month, Dey, Year): Dec. 26, 1997

30. Name end address of person who completed ceuse of deeth (Item 23e) (Type, Print): DR. DANIEL ROSENBLUM 10400 CONN. AVE. #606 KENSINGTON, MD 20895-3910

State Registrar

31. Date filed (Month, Dey, Yeer): DEC29 1997

32. Registrer's Signature: Linda Davidson-Rogers

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41039

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Betty Jane Skinner	December 31, 1997	6:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
3410 Hewitt Avenue Apt. 201	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
378-20-9248	1☐ M 2☒ F	71 Yrs.			Oct. 31, 1926	Michigan

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3410 Hewitt Avenue Apt. 201	20906	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
10		Clerk	Clerical

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Leo Bricker	Unknown Siler

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Paul J. Skinner (son)	8308 Larchwood Street, New Carrollton, MD 20874

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Metropolitan Crematory	12/31/97	Alexandria, VA

21. Signature of Funeral Service Licensee: L. Kevin Gutowski

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. CORONARY ARTERY DISEASE	years.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

COPD
HTN
Hyperlipidemia.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐ Yes 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
MD	P38457	DECEMBER 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N. GOYAL MD 1811 PRINCE PHILIP DRIVE, OLNEY MD 20832

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 02 1998	Julia Davidson-Randolph

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41040

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Stein
2. Date of Death (Month, Day, Year): December 26, 1997
3. Time of Death: 3:30am
4a. Facility Name (If not institution, give street and number): The Hebrew Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-54-6090
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 17, 1903
9. Birthplace (State or Foreign Country): PA

Usual Residance of Decedant

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6121 Montrose Rd.
10f. Zip Coda: 20852
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armad Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada compliated): Elementary/Secondary (0-12): 12 | Collega (1-4or 5+):
16a. Dacedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Benjamin Broker
18. Mothar's Neme (First, Middle, Maidan Sumama): D'Vora Saltz

19a. Informant's Name/Ratationship (Type, Print): Harold Stein/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda): 2420 Parallel La Silver Spring, MD 20904

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Nama of cematary, cramatory or othar place): King David Mem. Gdns.
Data: 12/28/97
20c. Location - City or Town, Stata: Falls Church, VA

21. Signature of Funaral Service Licensee: [signature]
22. Nama and Address of Facility: Ives-Pearson Funeral Homes 2847 Wilson Blvd. Arlington, VA 22201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter tha disaase, or complications that causad the death. Do not anter tha moda of dying, such as cardiac or respiretory arrest, shock, or heart taitura. List only ona causa on aach lina.

Approximate Intarval Batween Onsat and Death

Immediata Causa (Final disaesa or condition resulting in death)
a. Pneumonia — 1 day

Due to (or es e consequance of):
b. Parkinson's disease — years

Sequentially list conditions, if any, laeding to immadiata ceuse. Enter Underlying Causa (Diseasa or Injury that Initiated events resulting in daath) Last

Due to (or as a consaquance of):
c.

Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.
Left foot abscess, renal insufficiency, vascular dementia

23b. Did tobacco uaa contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was cesa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death (Check only ona): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Rasidence 8☐ Othar (Specify)

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Spacify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledga, death occurred at the time, data and place, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D23958
29d. Data signed (Month, Day, Year): 12/26/97

30. Nama and address of person who completed causa of death (Item 23a) (Type, Print): Burt I. Feldman MD 6105 Montrose Rd, Rockville MD 20852

State Registrar

31. Data filed (Month, Day, Year): DEC 31 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41041

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAGGIE L. STEPHENS

2. Date of Death (Month, Day, Year): DEC. 30, 1997

3. Time of Death: 10:50 Am

4a. Facility Name (If not institution, give street and number): Greenbelt Nursing Home

4b. City, Town, or Location of Death: Greenbelt

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577-12-4921

6. Sex: 1☐ M 2☒ F

7. Age (in yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr 26, 1913

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Md

10b. County: Montgomery

10c. City, Town or Location: Silver Spring,

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8505 Springvale Rd, #137

10f. Zip Code: 20910

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 2 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeper

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): George T. Sizer

18. Mother's Name (First, Middle, Maiden Surname): Virginia R. Taylor

19a. Informant's Name/Relationship (Type, Print): Virginia R. Coletrane (Dau.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13620 Bentley Cir., Woodbridge, VA 22192

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cem.

Date: 1/10/98

20c. Location - City or Town, State: Silver Spring, MD

21. Signature of Funeral Service Licensee: George R. Snowden

22. Name and Address of Facility: SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. ACUTE MYOCARDIAL INFARCTION — < 30'

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M. S. Nayar

29c. License number: D-17874

29d. Date signed (Month, Day, Year): 12-31-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. M. NAYAR, MD. 3717-38th AVE COTTAGE CITY, MD 20722

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998

32. Registrar's Signature

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41042

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frank Alvin Stone

2. Date of Death (Month, Day, Year): December 25, 1997

3. Time of Death: 7:30 PM

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 197-28-8219

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 26, 1938

9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7011 Lemay Rd.

10f. Zip Code: 20851

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: 1956-60

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4 or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Funeral Director

16b. Kind of Business/Industry: Funeral Home

17. Father's Name (First, Middle, Last): John T. Stone

18. Mother's Name (First, Middle, Maiden Surname): Mary Mc Cready

19a. Informant's Name/Relationship (Type, Print): John T. Stone (Brother)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 491 Pike Run Dr., Daisytown, Pennsylvania 15427

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Cem.

Date: 12-29-97

20c. Location - City or Town, State: Adelphi, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, MD 20852

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CEREBRO VASCULAR ACCIDENT — 5 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D07099

29d. Date signed (Month, Day, Year): DEC 25 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS C MAYLE 10215 FERNWOOD RD BETHESDA MD 20817

State Registrar

31. Data filed (Month, Day, Year): DEC 29 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41043

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Philip Johnson Stone

2. Date of Death (Month, Day, Year): Dec. 28, 1997

3. Time of Death: 9:45 A.M.

4a. Facility Name (If not institution, give street and number): Carriage Hill Nursing Home

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-58-5175

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 14, 1907

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: none

10b. County: none

10c. City, Town or Location: Washington, D.C.

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3023 Macomb Street, N.W.

10f. Zip Code: 20008

10g. Citizen of What Country? U.S.A.

11. Meritel Status: 1 [ ] Never Merried 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): | College (1-4or 5+): 4

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Librarian

16b. Kind of Business/Industry: D.C. Public Library

17. Fether's Neme (First, Middle, Last): George Fred Stone

18. Mother's Neme (First, Middle, Meiden Surneme): Florence Bennett Johnson

19a. Informent's Neme/Reletionship (Type, Print): Edward J. Stone/nephew

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1111 Westmoreland Rd.,Alexandria, Va. 22308

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Metropolitan Crematory | Dete: Dec.29,97

20c. Location - City or Town, Stete: Alexandria, Va.

21. Signeture of Funerel Service Licensee: Jay C. Wan

22. Neme end Address of Feciliity: DeVol Funeral Home 2222 Wisconsin Ave.,N.W.,Wash.,DC 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Death

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. pancreatic cancer

Due to (or as a consequence of):

Sequentielly list conditions, if any, leeding to Immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest: b. respiratory arrest

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one): Hospitel: 1 [ ] inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined

28a. Dete of injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner es stated. 2 [ ] Medicel Exeminer: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Christopher Unger

29c. License number: D15929

29d. Date signed (Month, Dey, Year): Dec. 29, 1997

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Christopher Unger, M.D., 8218 Wisconsin Ave., #208, Bethesda, MD. 20814-3169

State Registrar

31. Dete filed (Month, Dey, Year): DEC 30 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41044

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Chhay HUY SUN
2. Date of Death Month Day Year: December 27 1997
3. Time of Death: 0926 A
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 215-96-9013
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 7, 1915
9. Birthplace (State or Foreign Country): Cambodia

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 8454 Meadow Green Way
10f. Zip Code: 20877
10g. Citizen of What Country?: Cambodia

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Businesswoman
16b. Kind of Business/Industry: Import/Export

17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): David Ching (Son)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8454 Meadow Green Way, Gaithersburg, MD 20877

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): National Memorial Park
Date: 1/3/1998
20c. Location - City or Town, State: Falls Church, Virginia

21. Signature of Funeral Service Licensee: Michael D Cadden
22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Cardiopulmonary Arrest — minutes
Due to (or as a consequence of):
b. Sepsis — 2-3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Hyperosmolar Diabetic coma — 2-3 days
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jonathon MD
29c. License number: D 51714
29d. Date signed (Month, Day, Year): December, 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JATINDER S. SEKHON. M.D. 501 NORTH FREDRICK AVENUE. SUITE 102. GAITHERSBURG MARYLAND-20877

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997
32. Registrar's Signature: Gloria Davidson-Randolph

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41045

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Winfield Webster Sunderland
2. Date of Death Month / Day / Year: Dec. 23, 1997
3. Time of Death: 7:45PM
4a. Facility Name *(If not institution, give street and number)*: 5300 Westpath Way
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 371-05-1168
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 29, 1911
9. Birthplace *(State or Foreign Country)*: Swanton, VT

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5300 Westpath Way
10f. Zip Code: 20816
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Chemist
16b. Kind of Business/Industry: Dow Chemical Company

17. Father's Name *(First, Middle, Last)*: Hollis Sunderland
18. Mother's Name *(First, Middle, Maiden Surname)*: Mabel Knight

19a. Informant's Name/Relationship *(Type, Print)*: Lisa Sunderland-Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5300 Westpath Way Bethesda, MD 20816

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Comfort Crematory
Date: 12/29/97
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: Richard M. Peters
22. Name and Address of Facility: Joseph Gawler's Sons INC 5130 Wisconsin Ave. NW Washington, DC 20016

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrast, stock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Aspiration Pneumonia — Days

Due to (or as e consequence of):
Diabetes Mellitus — Decades

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as e consequence of):
c. Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.
Organic Brain Syndrome

23b. Did tobacco use contribute to the cauee of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office buiiding, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and menner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piace, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: Daniel V. Young M.D.
29c. License number: D40279
29d. Data signed *(Month, Day, Year)*: Dec. 24, 1997
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Daniel V. Young MD., 4910 Massachusetts Ave. NW #312 Washington, DC 20016

State Registrar

31. Date filed *(Month, Day, Year)*: DEC29 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #26, Per Phy. 12/23/97, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41046

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marion Shipley
2. Date of Death Month Dey Year: December 17th 1997
3. Time of Death: 14:39
4a. Facility Name (If not institution, give street and number): Northwest Hospital Center
4b. City, Town, or Location of Death: Randallstown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 217-12-1488
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Dey, Year): MAy 14, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Westminster
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 2306 Littlestown Pike
10f. Zip Code: 21157
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorcad
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 9th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): RMC Motors, Inc.
16b. Kind of Business/Industry: Maintenance Man

17. Father's Name (First, Middle, Last): Herbert Shipley
18. Mother's Name (First, Middle, Malden Sumame): Cleedie Gibson

19a. Informent's Name/Relationship (Type, Print): Brenda Reese (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 60 Red Hill Rd. New Oxford, PA 17350

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Placa of Disposition (Name of cemetery, crematory or other place): Harmony Grove Cemetery
Date: 12/22/97
20c. Location - City or Town, State: Gist, MD

21. Signeture of Funeral Servica Licensee: Todd A. Killen
22. Name end Address of Facility: Burrier-Queen Funeral Home 1212 W. Old Liberty Rd. Winfield, MD 21784

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one cause on eech line.

		Approximete Interval Between Onset and Death
Immediate Cause (Finel disease or condition resulting in death) a.	Acute Respiratory Failure	30 minutes
Due to (or as a consequence of): b.	Acute Pulmonary Embolism	30 minutes
Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last — Due to (or as e consequence of): c.	Alcoholic Liver Disease	3 years
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Anemia

23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Deeth (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA Other: 4 ☒ ~~Nursing Home~~ 5 ☐ Reaidence 6 ☐ Other (Specify)
27. Manner of Deeth: 1 ☒ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Phyalcian:** To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) end menner as steted. 2 ☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated.

29b. Signature end title of certifier: Jay Zwally II, MD
29c. License number: D42684
29d. Date signed (Month, Day, Year): December 17th, 1997

30. Neme end addreas of person who completed cause of deeth (Item 23a) (Type, Print): JAY Zwally II Northwest Hospital Center 5401 Old Court Rd 21133

State Registrar

31. Date filed (Month, Day, Year): DEC 23 1997
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-7303-013
CIP
ELEANOR VELMA STALLO

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41047

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELEANOR VELMA STALLO

2. Date of Death: Month DECEMBER Day 18, Year 1997

3. Time of Death: 9:30AM

4a. Facility Name (If not institution, give street and number): 2175 OTTERDALE MILL ROAD

4b. City, Town, or Location of Death: TANEYTOWN

4c. County of Death: CARROLL

Funeral Director

5. Social Security Number: 212-03-5667

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 15, 1909

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll

10c. City, Town or Location: Taneytown

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 2175 Otterdale Mill Road

10f. Zip Code: 21787

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Reca - American Indien, Bleck, White, etc. Specify: Caucasian

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

18b. Kind of Business/Industry: Business

17. Fether's Neme (First, Middle, Last): Harry H. Lohr

18. Mother's Neme (First, Middle, Maiden Surneme): Mary Churchill Shroyer

19a. Informent's Neme/Relationship (Type, Print): Kim Tressler ? Friend

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 10301 Welty Rd., Emmitsburg, MD 21727

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, cremetory or other place): Trinity Lutheran Cem.

Date: 12/20

20c. Location - City or Town, State: Taneytown, MD 21787

21. Signature of Funeral Service Licensee: John M. Skiles M00534

22. Name end Address of Feciility: Skiles Funeral Home, 136 E. Baltimore St., Taneytown, MD 21787

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in deeth): e. ~~Arteriosclerotic Cardiovascular Disease~~

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest:

b. Due to (or es a consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? INSPECTED 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☒ Yes 2☐ No

26. Piece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☐ **Certifying Phyaician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end manner as stated. 2☒ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, dete and pieca, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Stephen R Radentz, MD

29c. License number: O.C.M.E.

29d. Dete signed (Month, Dey, Year): DECEMBER 18, 1997

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): STEPHEN RADENTZ M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year): DEC 24 1997

32. Registrer's Signeture: Julie Strecker Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41048

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Esther Elizabeth Shockey

2. Data of Death — Month: Dec. Day: 19 Yaar: 1997

3. Tima of Death: 9:00 pm

4a. Facility Nama *(If not institution, giva street and number)*: Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Numbar: 217-09-8400

6. Sax: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Undar 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: May 2, 1912

9. Birthplaca *(Stata or Foreign Country)*: Maryland

Usual Rasidanca of Decadant

10a. Stata: MD

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Numbar: 1775 Stone Chapel Road

10f. Zip Coda: 21157

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Naver Married 2☐ Marriad 3☒ Widowed 4☐ Divorced

12. Was Dacadent Evar in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yas, Giva Yaar or Datas:

13. Was Decadent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, White, atc. *Specify:* white

15. Decadent's Education *(Spacify only highest grada complatad)*: Elamantary/Secondary (0-12): 12 — Collaga (1-4or 5+):

16a. Dacadent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: worker

16b. Kind of Businass/Industry: Hospital

17. Fathar's Nama *(First, Middle, Last)*: Thomas Aro

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Elizabeth

19a. Informant's Name/Ralationship *(Type, Print)*: Leona V. Shockey, daughter

19b. Mailing Address *(Street and Numbar or Rural Routa Number, City or Town, Stata, Zip Code)*: 1775 Stone Chapel Rd., Westminster, MD 21157

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*

20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: Evergreen Memorial Gardens — Data: 12/22/97

20c. Location - City or Town, Stata: Finksburg, MD

21. Signature of Funaral Sarvice Licensee: ▶ Katherine Pritts - Sweitzer

22. Nama and Address of Facility: Pritts Funeral Home & Chapel, 412 Washington Rd., Westminster, MD

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that caused the daath. Do not antar the mode of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Batwaen Onsat and Death

Immediata Causa (Final disaasa or condition resulting in daath)
a. Acute Small Bowel Obstruction — one day

Dua to (or as a consaquanca of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiatad avants resulting in daath) Last
b.

Dua to (or as a consaquanca of):
c.

Dua to (or as a consaquanca of):
d.

Part II. **Othar significant conditions** contributing to daath but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco usa contributa to the cauaa of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to compiation of cause of daath? 1☐ Yas 2☒ No

25. Was casa rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only one)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarminad

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Straat and Numbar or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Cartifying Phyaician:** To tha bast of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examinar:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signature and tita of cartifiar: ▶ [signature] M.D. (HOUSE OFFICER)

29c. License number: D51664

29d. Date signed *(Month, Day, Year)*: December 19 1997

30. Nama and addrass of parson who complatad causa of daath (Itam 23a) (Typa, Print): SUDHIR KUMAR AGGARWAL — Carroll County General Hospital, 200 Memorial Ave., Westminster, MD

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 23 1997

32. Registrar's Signature: ▶ Julie Strecker Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41049

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANK RAHM Stoner III
2. Date of Death: Month Dec. Day 26 Year 1997
3. Time of Death: 2:05 p.m.
4a. Facility Name (If not institution, give street and number): WILLIAM HILL MANOR-HEALTHCARE
4b. City, Town, or Location of Death: EASTON
4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 203-22-4648
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): SEPT.15,1928
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MD
10b. County: TALBOT
10c. City, Town or Location: EASTON
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6065 HEDGES LANE
10f. Zip Code: 21601
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedant Evar in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yas, Giva Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yas or No- If Yes, spacify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specity:
14. Race - American Indian, Black, Whita, etc.: Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): SALES ENGINEER
16b. Kind of Business/Industry: INDUSTRIAL COATING
17. Father's Name (First, Middla, Last): FRANK RAHM STONER II
18. Mothar's Nama (First, Middle, Maiden Surneme): JANE NICHOLSON
19a. Informent's Neme/Reletionship (Type, Print): SARAH S. STONER/WIFE
19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code): 6065 HEDGES LANE, EASTON, MD 21601
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from Steta 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Placa of Disposition (Neme of cemetery, crematory or other place): CHESAPEAKE CREMATION CENTER LLC.
Dete: 12/27/97
20c. Location - City or Town, Stata: CHESTER,MD
21. Signature of Funeral Service Licensee: Maura G Mann IV
22. Nama and Address of Facility: FELLOWS, HELFENBEIN, & NEWNAM FUNERAL HOME 200 S. HARRISON STREET, EASTON, MD 21601

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilura. List only ona ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Finel disaesa or condition resulting in death):
a. Cerebrovascular accident — 2 days

Due to (or as a consequence of):
b. Atherosclerotic cardiovascular disease — years

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last

Due to (or as a consequence of):
c. Hypertension — years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

metastatic prostate carcinoma

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Ware autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yas 2 [X] No

26. Plece of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and menner as steted. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: David G Oliver MD
29c. License number: D39749
29d. Date signed (Month, Day, Year): 12/27/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): David G Oliver MD 503 Atchmans Lane Easton MD 21601

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that tha death certificata be executed within 24 hours after death.
To the Funeral Director: After this certificata has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for usa as the burial-transit

State Registrar

31. Data filed (Month, Dey, Year): DEC 29 1997
32. Registrer's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41050

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CLEMENT E. TENNYSON, JR.
2. Date of Death (Month, Day, Year): December 28, 1997
3. Time of Death: 10:43 AM
4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital
4b. City, Town, or Location of Death: Takoma Park
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-32-7126
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 10, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 10202 Carson Place
10f. Zip Code: 20901
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Branch Manager
16b. Kind of Business/Industry: Moving Industry

17. Father's Name (First, Middle, Last): Clement E. Tennyson, SR.
18. Mother's Name (First, Middle, Maiden Surname): Mary Harris

19a. Informant's Name/Relationship (Type, Print): Helen C. Tennyson (wife)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10202 Carson Place, Silver Spring, MD 20901

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 12/31/97
20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: John L Chapin
22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Coronary Artery Disease	1 year
Due to (or as a consequence of): b.	Recent Myocardial Infarction.	10 Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin Dependent Diabetes Mellitus.
Chronic Obstructive Lung Disease,
Renal insufficiency.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residance 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Arvind M. Mehta MD
29c. License number: D27366
29d. Date signed (Month, Day, Year): 12/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ARVIND M. MEHTA, 7100 Baltimore Ave #509, College Park MD 20740.

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit order.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41051

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Richard H. Tubbs

2. Date of Death Month / Day / Year: December 25, 1997

3. Time of Death: 7:45 AM

4a. Facility Name *(If not institution, give street and number)*: 11204 Lund Place

4b. City, Town, or Location of Death: Kensington

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 021-18-2699

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 20, 1922

9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residance of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 11204 Lund Place

10f. Zip Code: 20895

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowad 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Datas: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12) / College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Public Information

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: Robert J. Tubbs

18. Mother's Name *(First, Middle, Maiden Surname)*: Lucille Carter

19a. Informant's Name/Relationship *(Type, Print)*: Richard H. Tubbs, Jr. (son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6901 Neuhoff Lane Charlotte, North Carolina 28269

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other placa)*: Gate of Heaven Cemetery | Date: 12/29/97

20c. Location - City or Town, Stete: Silver Spring, Maryland

21. Signature of Funeral Service Licensaa: William L Byrd

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode ot dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Ceuse (Final disaase or condition resulting in death)
a. Squamous Cell Carcinoma Jaw Unknown Primary

Due to (or as a consequence ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last
b.

Due to (or es a consequence ot):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specity)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, end due to the cause(s) and manner as steted. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete end piece, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. Licanse number: D18137

29d. Date signed *(Month, Day, Year)*: 12/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey Drobis, M.D. 12201 Plum Orchard Drive Silver Spring, Maryland 20904

State Registrar

31. Deta filed *(Month, Day, Year)*: DEC 29 1997

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41052

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Gregory Thompson

2. Date of Death (Month, Day, Year): December 22, 1997

3. Time of Death: 4:16p.m.

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital of Silver Spring

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 217-48-0297

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 16, 1926

9. Birthplace (State or Foreign Country): Washington D.C.

Usual Residence of Decedent

10e. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 14013 Notley Rd.

10f. Zip Code: 20904

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor of Library

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): William Bingley Thompson

18. Mother's Name (First, Middle, Maiden Surname): Mary Jane Gregory

19a. Informant's Name/Relationship (Type, Print): Evelyn Thompson/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14013 Notley Rd.Silver Spring, MD 20904

20e. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Evergreen Memorial Gard.

Date: 12/26/97

20c. Location - City or Town, State: Finksburg, MD

21. Signature of Funeral Service Licensee: Robert D. Myers

22. Name and Address of Facility: 91 Willis Street Myers Funeral HomeWestminster, MD 21157

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Acute pneumonia — Approximate Interval: 24hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Glioblastoma Multiforme

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Myron L. Lenkin MD

29c. License number: D06674

29d. Date signed (Month, Day, Year): 12/22/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MYRON L. LENKIN 2309 SHOREFIELD RD WHEATON MD 20902

State Registrar

31. Date filed (Month, Day, Year): DEC 24 1997

32. Registrar's Signature: Julia Thurber Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41053

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frank Varano
2. Date of Death Month Day Year: December 30, 1997
3. Time of Death: 7:28 PM
4a. Facility Name *(If not institution, give street and number)*: 10706 Bentley Lane
4b. City, Town, or Location of Death: Kensington
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 155-03-2890
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Dec. 31, 1914
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Kensington
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 10706 Bentley Lane
10f. Zip Code: 20895
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): Collaga (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: Pianist
16b. Kind of Business/Industry: Entertainment

17. Father's Name *(First, Middle, Last)*: Joseph Varano
18. Mother's Name *(First, Middle, Maiden Surname)*: Luisa Tursi

19a. Informant's Name/Relationship *(Type, Print)*: Gary R. Varano/Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10710 Bentley Lane, Kensington, Maryland 20895

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Parklawn Memorial Park — Date: Jan. 2, 1998
20c. Location - City or Town, State: Rockville, Maryland

21. Signature of Funeral Service Licensee: Ray Faust M00198
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Prostate Cancer — 6 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Squamous cell carcinoma of the skin

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Anthony Arcenas
29c. License number: D20459
29d. Date signed *(Month, Day, Year)*: January 1, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Anthony Arcenas, M.D. Veterans Administration Medical Center, Washington, D.C.

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 02 1998
32. Registrar's Signature: Julia Davidson-Rondeau

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41054

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Friedrich O. VonBun

2. Date of Death Month / Day / Year: December 26 1997

3. Time of Death: 0845

4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 145-28-8972

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 72 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 22, 1925

9. Birthplace *(State or Foreign Country)*: Germany

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12506 White Drive

10f. Zip Code: 20904

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 12; College (1-4or 5+): 6+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Physicist

16b. Kind of Business/Industry: NASA

17. Father's Name *(First, Middle, Last)*: Unobtainable

18. Mother's Name *(First, Middle, Meiden Surname)*: Elfriede von Bun

19a. Informant's Name/Relationship *(Type, Print)*: Maria von Bun / Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 12506 White Drive, Silver Sprung, Maryland 20904

20a. Method of Disposition: 1☐ Buriel 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Fort Lincoln Crematory

Date: 12/29/97

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Alan J Donnell

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert tailure. List only ona cause on eech line.

Approximata Interval Batween Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Multiple system organ failure — days

Due to (or as a consequanca of):

b. Ischemi cardiomyopathy — days

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequance of):

c.

Due to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings evelleble prior to compiation of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examinar? 1☐ Yes 2☒ No

26. Plece of Death *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determinad

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, tarm, street, tactory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurrad at the time, data and placa, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examinar:** On the basis of examination end/or investigation, in my opinion, daath occurred at the time, dete and place, end due to the cause(s) and mannar statad.

29b. Signature and title of certifier:

29c. License number: D40119

29d. Date signed *(Month, Day, Year)*: December 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Steven Boyce 706 Irving Street S.W. Suite 308 Washington DC 20010

State Registrar

31. Date filed *(Month, Day, Yaar)*: DEC 29 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5(10)

Medical Certification: To Be Completed by Physician/Medical Examiner

97 41055

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANKLIN VINCENT VLECK, SR.

2. DATE OF DEATH (Month, Day, Year): DEC 27, 1997

3. TIME OF DEATH: 12:00 PM

4. SOCIAL SECURITY NUMBER: 215-16-6769

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): MAY 18,1923

8. BIRTHPLACE (State or Foreign Country): WISCONSIN

9a. FACILITY NAME (If not institution, give street and number): CARROLL COUNTY GENERAL HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH: WESTMINSTER

9c. COUNTY OF DEATH: CARROLL

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: CARROLL

10c. CITY, TOWN OR LOCATION: NEW WINDSOR

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 1664 WAKEFIELD VALLEY ROAD

10f. ZIP CODE: 21776

10g. CITIZEN OF WHAT COUNTRY: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ENGINEER

16b. KIND OF BUSINESS/INDUSTRY: F.V. VLECK & COMPANY

17. FATHER'S NAME (First, Middle, Last): ADOLPH VLCEK

18. MOTHER'S NAME (First, Middle, Maiden Surname): FRANCES RMOUTILOVA

19a. INFORMANT'S NAME (Type/Print): RUTH ANNA VLECK, WIFE

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1664 WAKEFIELD VALLEY RD, NEW WINDSOR, MD 21776

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): CARROLL CREMATIONS — DATE: 12/28

20c. LOCATION — City or Town, State: HAMPSTEAD, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steve W Eline

22. NAME AND ADDRESS OF FACILITY: ELINE FUNERAL HOME, 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHRONIC LYMPHOCYTIC LEUKEMIA — Approximate Interval Between Onset and Death: 1 yr

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CEREBRAL HEMORRHAGE; LEFT LEG DEEP VENOUS THROMBOSIS

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [✓] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Flavio Kruter MD

29c. LICENSE NUMBER: D35 398

29d. DATE SIGNED (Month, Day, Year): ▶ 12/27/97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): FLAVIO KRUTER 684 A POOLE RD WESTMINSTER MD 21157

31. DATE FILED (Month, Day, Year): DEC 29 1997

32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41056

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sarah Victoria White

2. Date of Death: Month December Day 26 Year 1997

3. Time of Death: 12:30 PM

4a. Facility Name (If not institution, give street and number): Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-88-5003

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sep. 12, 1922

9. Birthplace (State or Foreign Country): Jamaica

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Brentwood

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4408 38th Street

10f. Zip Code: 20722

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Cornelius Lowe

18. Mother's Name (First, Middle, Maiden Surname): Lydia Harris

19a. Informant's Name/Relationship (Type, Print): Maudlyn A. White / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4408 38th Street, Brentwood, Maryland 20722

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery | Date: 1/3/98

20c. Location - City or Town, State: Silver Spring, Maryland

21. Signature of Funeral Service Licensee: ▶ Alex Cole

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Hypercalcemia	5 weeks
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Large Cell T-cell Lymphoma	3 months
Due to (or as a consequence of):		
	c. Renal Failure	1 week
Due to (or as a consequence of):		
	d. Congestive Heart Failure	1 week

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Malnutrition

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ David R. Brown MD

29c. License number: D36784

29d. Date signed (Month, Day, Year): 12-26-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): David R. Brown MD, 6510 Kenilworth Ave Ste 2100, Riverdale, MD 20737

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997

32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41057

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PATRICK JAMES WALSHE

2. Date of Death (Month, Day, Year): DECEMBER 27, 1997

3. Time of Death: 11:35A.M.

4a. Facility Name (If not institution, give street and number): N.I.H. CLINICAL CENTER

4b. City, Town, or Location of Death: BETHESDA

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 593-16-3495

6. Sex: 1 [X] M 2 [ ] F

7. Age (in yrs. last birthday): 27 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): APR. 16, 1970

9. Birthplace (State or Foreign Country): MASS.

Usual Residence of Decedent

10a. State: FLA.

10b. County: ORANGE

10c. City, Town or Location: ORLANDO

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5136 PINE TOP PL.

10f. Zip Code: 32819

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DEPUTY SHERIFF

16b. Kind of Business/Industry: ORANGE CO.

17. Father's Name (First, Middle, Last): BRENDAN J. WALSHE

18. Mother's Name (First, Middle, Maiden Surname): KATHY E. YOUNG

19a. Informant's Name/Relationship (Type, Print): KATHY HOWARD/MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ITEM #10

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): WOODLAWN CEMETERY

Date: 1/3/98

20c. Location - City or Town, State: GOTHA, FLA.

21. Signature of Funeral Service Licensee: W. W. Chambers MO0091

22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. MELANOMA — WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ervant Nishanian MD

29c. License number: 81166-MASS.

29d. Date signed (Month, Day, Year): 12-27-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERVANT NISHANIAN, M.D. 9000 ROCKVILLE PIKE, BETHESDA, MARYLAND 20892

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997

32. Registrar's Signature: Julia Davidson-Ringgold

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41058

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MYRTLE VONCILLE WHITE

2. Date of Death Month / Day / Year: DEC. 30, 1997

3. Time of Death: 12:30 AM

4a. Facility Name *(If not institution, give street and number)*: MAGNOLIA CENTER NURSING HOME

4b. City, Town, or Location of Death: LANHAM

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 417-18-7736

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 24, 1916

9. Birthplace *(State or Foreign Country)*: Alabama

Usual Residence of Decedent

10a. State: Md.

10b. County: P.G.

10c. City, Town or Location: Lanham

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8200 Goodluck Rd.

10f. Zip Code: 20706

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): ------

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Grover Wesley Taunton

18. Mother's Name *(First, Middle, Maiden Surname)*: Naomi Dopson

19a. Informant's Name/Relationship *(Type, Print)*: Hugh E. White (Son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4319 N.E. 26th.Crt. Vancouver, Washington 98663

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Old Watson Chapel Cemetery | Date: 1/2/98

20c. Location - City or Town, State: Eclectic, Alabama

21. Signature of Funeral Service Licensee: Thomas S. Chambers #679

22. Name and Address of Facility: Chambers Funeral Homes, P.A. 5801 Cleveland Ave. Riverdale, Md. 20737

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — days

Due to (or as a consequence of):
b. Senile Dementia — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: None

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peter M Schissler MD

29c. License number: 022750

29d. Date signed *(Month/Day, Year)*: 12/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter M Schissler MD 7500 Greenway Ctr. Dr. Greenbelt Md 20770

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 31 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41059

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Odell L. Whipple, Jr.

2. Date of Death (Month, Day, Year): December 29, 1997

3. Time of Death: 4:40 AM

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-05-5434

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 26, 1911

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Chevy Chase

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5500 Friendship Blvd. #2408North

10f. Zip Code: 20815

10g. Citizen of What Country? United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Landscaper

16b. Kind of Business/Industry: Landscaping

17. Father's Name (First, Middle, Last): Odell L. Whipple, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Nancy Williams

19a. Informant's Name/Relationship (Type, Print): Mary I. Lintner/Executor

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5500 Friendship Blvd., Chevy Chase, MD 20815

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc. Date: Jan. 2, 1998

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: Ray Faul M00198

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

BHW

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia with Bilateral Pleural Effusions — 1 week

Due to (or as a consequence of):

b. Atrial Fibrillation

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Gastric Erosions

Due to (or as a consequence of):

d. Esophagitis

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure

Colitis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Wilhemina J. Nicola

29c. License number: D45285

29d. Date signed (Month, Day, Year): December 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): W.J. Nicola, 18111 Prince Phillip Dr, Suite 212, Olney, Md

4

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998

32. Registrar's Signature: Julia Davidson-Rondeau

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41060

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DAVID LEE WILLIAMS

2. Date of Death Month Day Year: December 27, 1997

3. Time of Death: 4:00pm.

4a. Facility Name (If not institution, give street and number): Doctors Community Hospital

4b. City, Town, or Location of Death: LANHAM

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577-62-8795

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): JAN. 11, 1948

9. Birthplace (State or Foreign Country): WASH. D.C.

Usual Residence of Decedent

10a. State: MD.

10b. County: PRINCE GEORGES

10c. City, Town or Location: LANHAM

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 5538 RUXTON DR.

10f. Zip Code: 20706

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CONTRACTOR

16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): LUCIUS G. WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname): MAGGIE SAUNDERS

19a. Informant's Name/Relationship (Type, Print): PATTY L. WILLIAMS/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ITEM #10

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): CHAMBERS CREMATORY

Date: 12/31/97

20c. Location - City or Town, State: RIVERDALE, MD.

21. Signature of Funeral Service Licensee: W.W. Chambers MO0091

22. Name and Address of Facility: CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. HEPATIC FAILURE — CHRONIC

Due to (or as a consequence of):
b. END STAGE LIVER DISEASE — CHRONIC

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last
Due to (or as a consequence of):
c. CIRRHOSIS — CHRONIC

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as steted. 2 [ ] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph Robinson MD

29c. License number: D24712

29d. Date signed (Month, Dey, Year): 12/30/97

30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print): JOSEPH ROBINSON, MD 10274 LAKE ARBOR WAY, MITCHELLVILLE, MD 20721

State Registrar

31. Dete filed (Month, Day, Yeer): DEC 31 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41061

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Harry Wishnack

2. Dete of Deeth: Month Dec Day 29 Year 1997

3. Time of Death: 02:15AM

4e Fecility Neme (If not institution, give street and number): Holy Cross Hospital

4b. City, Town, or Location of Deeth: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 112 10 6623

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months Days

If Under 24 Hrs.: Hours Min.

8. Dale of Birth (Month, Dey, Year): June 201911

9. Birthplace (State or Foreign Country): New York

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Montgomery

10c. City, Town or Locelion: Kensington

10d. Inside City Limits: 1☒Yes 2☐No

10a. Streel end Number: 3616 Littledale Road

10f. Zip Code: 20895

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedenl Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 College (1-4or 5+):

16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Sales

16b. Kind of Business/Industry: Shoe Company

17. Fether's Neme (First, Middle, Last): Joseph Wishnack

18. Mother's Name (First, Middle, Meiden Surname): Dora Zysman

19a. Informent's Name/Reletionship (Type, Print): Roberta Amy Wigodsky Daughter

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 8 Turnham Lane Gaithersburg, MD 20878

20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other (Specify)

20b. Placa of Disposition (Neme of cemetery, crematory or other piece): Judean Mem Gdns.

Dete: 12/30

20c. Location - City or Town, State: Olney, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Fecility: Ives Pearson Funeral Home 22046 472 N. Washington St Falls Church, VA

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)

a. Respiratory failure — Sudden

Due to (or es e consequence of):

b. Stroke — Days

Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in deeth) Lest

Due to (or es e consequenca of):

c. Hypertension — Yeay

Due to (or es e consequence of):

d.

Pert II. Other significant conditione contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

23b. Did tobacco uee contribute to the ceuse of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eulopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one): Hospitel: 1☒ Inpetienl 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigelion 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, streel, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner es steted. 2☐ Medical Examiner: On the besis of exemination and/or investigetion, in my opinion, deeth occurred et the time, dete and place, and due to the cause(s) end manner stated.

29b. Signeture and litle of certifier: [signature] MD

29c. License number: D-32332

29d. Date signed (Month, Dey, Year): Dec 29, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): SK GUPTA, MD 9801 Georgia Ave # 220 SILVER SPRING MD 20902

State Registrar

31. Dete filed (Month, Dey, Year): DEC 31 1997

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41062

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martha Louise Wood
2. Date of Death Month: 12 Day: 25 Year: 1997
3. Time of Death: 435 am
4a. Facility Name (If not Institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 214-03-9380
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct 18, 1913
9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Laurel
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 345 Brock Bridge Road
10f. Zip Code: 20724
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 3 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Hair Dresser
16b. Kind of Business/Industry: Beauty Salon

17. Father's Name (First, Middle, Last): William T. Bruff
18. Mother's Name (First, Middle, Maiden Surname): Ellen Lyons

19a. Informant's Name/Relationship (Type, Print): Elizabeth Russo/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6297 Woodcrest Drive, Ellicott City, Maryland21043

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.
Date: 12/27
20c. Location - City or Town, State: Catonsville, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Interval Between Onset end Death: days

Immediete Ceuse (Finel diseese or condition resulting in death)
e. Sepsis
Due to (or es e consequence of):
b. Acute Respiratory Infection
Sequentielly list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
Due to (or es a consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
(1) Senility
(3) Cerebral Debility
(3). Old Age

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☐ Medical Examiner: On the besis of exemination end/or investigetion, in my opinion, deeth occurred at the time, dete and piece, and due to the ceuse(s) end menner steted.
29b. Signeture end title of certifier: [signature]
29c. License number: D 13687
29d. Dete signed (Month, Dey, Year): 12-27-97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Jorgito D. Magday, MD PA 11701 Rebey Ave, Baltimore MD 20705

State Registrar

31. Dete filed (Month, Dey, Year): DEC 29 1997
32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41063

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
Eric	Meng Chin	Yuan	December	31	1997	4:35PM

4e Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
601 Springloch Road	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (in yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-46-2442	XM 2 F	78 Yrs.					Dec 10, 1919	China

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Montgomery	Silver Spring	1 Yes XX No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
601 Springloch Road	20904	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 3 XX Widowed 4 Divorced	1 Yes 2 XX No If Yes, Give Year or Dates:	1 Yes 2 XX No Specify:	Specify: Asian

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamentary/Secondary (0-12)	College (1-4or 5+)		
	5+	Linguist	Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Jia-Chi Yuan	Gui-Lian Yu

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ray Yaun (Son)	14932 McKnew Road, Burtonsville, MD 20866

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 Burial 2 XX Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Metropolitan Crematory	Jan 2, 1998	Alexandria, VA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Steven D Strand	Francis J. Collins Funeral Home 500 University Blvd. West, Silver Spring MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Cerebral Vascular Accident	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 X Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined		M	1 Yes 2 No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ William C. Liu	MD 00002555	January 1, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Dr. William Liu, 2902 Porter Street, NW, Washington D.C. 20008-3286

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 02 1998	Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41064

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
ETHEL AGNES YOST	DEC 25, 1997	10:00 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
LONG VIEW NURSING HOME	MANCHESTER	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
217-01-0872	1☐ M 2☒ F	91 Yrs.			SEP 7,1906	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	CARROLL	HAMPSTEAD	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1422 FAIRMOUNT ROAD	21074	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
6		SEAMSTRESS	WESTMINSTER SEWING FACTORY

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
WILLIAM ELLSWORTH FREDERICK	LOTTIE V. KREITZER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RAYMOND R. HALE, SON	2201 FAIRMOUNT RD, HAMPSTEAD, MD 21074

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	NEW LUTHERAN CEMETERY	12/29	MANCHESTER, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Steven W. Eline	ELINE FUNERAL HOME 934 SOUTH MAIN ST, HAMPSTEAD, MD 21074

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Alzheimer's Dementia	years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ MD	D33165	12/26/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Steven Shaffer 2111 Hanover Pike Hampstead MD 21074

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 29 1997	▶ Julia Strickler Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41065

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): CORA ZIMMERMAN
2. Dete of Deeth: Month December Dey 26 Yeer 1997
3. Time of Death: 930 PM
4a. Feciity Neme (If not institution, give street and number): Laurel Regional Hospital
4b. City, Town, or Location of Death: Laurel
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 216-58-7688
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): March 22, 1916
9. Birthplace (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Prince George's
10c. City, Town or Location: Beltsville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 5009 Olympia Avenue
10f. Zip Code: 20705
10g. Citizen of Whet Country?: United States

11. Maritel Stetus: 1☐Never Merried 2☐Married ☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.): 1☐Yes 2☒No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Busineee/Industry: own home
17. Father's Neme (First, Middle, Last): John Henry Ford
18. Mother's Neme (First, Middle, Meiden Surneme): Cora Harriet Virginia Whipp
19a. Informent's Neme/Reletionship (Type, Print): Donald E. Zimmerman (son)
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 4311 Wilkerson Road Brandywine, Maryland 20613
20e. Method of Disposition: ☒Burial 2☐Cremetion 3☐Removal from Stete 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Mt. Olivet Cemetery
Dete: 12/31/1997
20c. Locetion - City or Town, Stete: Frederick, Maryland
21. Signeture of Funerel Service Licensee: ▶ Donald V. Borgwardt.
22. Neme end Address of Feciity: Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Road Beltsville, Maryland 20705

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that ceused the death. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth)
e. Lymphoma, Small Bowel — > 1 year
Due to (or as a consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest
b.
Due to (or es e consequence of):
c.
Due to (or es e consequance of):
d.

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☑No 3☐Probably 4☐Unknown

24e. Wes an eutopsy performed? 1☑Yes 2☐No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐Yes 2☑No

25. Wes case referred to medical exeminer? 1☐Yes 2☑No

26. Piece of Deeth (Check only one): Hospital: 1☑Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Deeth: 1☑Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)
28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) end manner es stated. 2☐**Medical Examiner:** On the basis of exemineti on end/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end mennar steted.

29b. Signeture end title of certifier: ▶ Andrew Kumerer
29c. License number: 036716
29d. Dete signed (Month, Dey, Yeer): December 27, 1997

30. Neme end address of person who completed ceuse of deeth (Item 23a) (Type, Print): Andrew Kumerer, M.D. 8317 Cherry Lane, Laurel, Md 20707

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 30 1997
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41066

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert DUNN
2. Date of Death (Month, Day, Year): December 20, 1997
3. Time of Death: 10:00 P.M.
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital Center
4b. City, Town, or Location of Death: Rosedale
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number:
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 10, 1925
9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD. | 10b. County: N/A | 10c. City, Town or Location: BALTIMORE | 10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4320 CLAREWAY APT. 6G | 10f. Zip Code: 21213 | 10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No. If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DISABLED

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): ROSE BURDYCK

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 713 S. ROBINSON ST. BALTO., MD. 21224

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): OAKLAWN CEM. | Date: DEC. 23 1997

20c. Location - City or Town, State: BALTO - CO. MD.

21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.

22. Name and Address of Facility: SKARDA F.H. 2829 HUDSON ST. BALTO. MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Hypoxemia — 48 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Hypotension

Due to (or as a consequence of):

c. Pneumonia

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year) | 28b. Time of Injury M | 28c. Injury at Work? 1 [ ] Yes 2 [ ] No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DO

29c. License number: D52379

29d. Date signed (Month, Day, Year): 12/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Savitha Shivananda 9000 Franklin Square Dr. Baltimore, Maryland 21237

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #24a,29a perPhy @755 1/14/98 EW

Certificate of Death

Reg. No. 97 41067

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Griffith

2. Date of Death — Month: December Day: 6 Year: 1997

3. Time of Death: 11:14 AM

4a. Facility Name (If not institution, give street and number): Mercy Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 218-05-8254

6. Sex: 1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 20, 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 317 Park Avenue

10f. Zip Code: 21201

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 8 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Painter

16b. Kind of Business/Industry: Painting

17. Father's Name (First, Middle, Last): Olin M. Griffin

18. Mother's Name (First, Middle, Maiden Surname): Margaret Wheeler

19a. Informant's Name/Relationship (Type, Print): Eleanor Brown/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2017 Warwick Drive, Orlando, Florida 32826

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Acute myocardial infarction	1 day
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Cardiogenic pulmonary edema	1 day
Due to (or as a consequence of):		
c.	Cardiogenic shock	10 hrs
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) — Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D14447

29d. Date signed (Month, Day, Year): 12/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mercy Medical Center 301 St Paul Pl Baltimore 21202

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41068

Amended #24a perPHY G755 1/14/98 EW

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gerard William Gordon

2. Date of Death: Month November Day 26 Year 1997

3. Time of Death: 9:45 PM

4a. Facility Name (If not institution, give street and number): Medpoint Nursing Home

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 080-36-0213

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 52 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 19, 1945

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Elkton

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 265 Starkey Lane

10f. Zip Code: 21921

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Driver

16b. Kind of Business/Industry: Trucking

17. Father's Name (First, Middle, Last): Ernest Gordon

18. Mother's Name (First, Middle, Maiden Surname): Marie Schurmann

19a. Informant's Name/Relationship (Type, Print): Mary Ann Gordon/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 265 Starkey Lane, Elkton, MD 21921

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):

a. Progressive Liver Failure — months

Due to (or as a consequence of):

b. Metastatic biliary cancer — months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D45155

29d. Date signed (Month, Day, Year): 12-3-1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN RICHARD MULVEY 118 NORTH ST SUITE 2A ELKTON MD 21921

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1998

32. Registrar's Signature: Gloria Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97-7454-510

Item 26,28e Per MEO Film G755 1-14-98 rja

ASP
JERRY JOHNSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41069

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JERRY LEE JOHNSON
2. Date of Death (Month, Day, Year): DECEMBER 25 1997
3. Time of Death: 4:15 A
4a. Facility Name (If not institution, give street and number): 1702 ASHBURTON ST.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-62-4951
6. Sex: 1 M 2 F
7. Age (In yrs. last birthday): 39 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 19, 1958
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Md
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 Yes 2 No
10e. Street and Number: 925 WICKLOW ROAD
10f. Zip Code: 21229
10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1977 1981
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11th grade; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CONSTRUCTION WORKER
16b. Kind of Business/Industry: PRIVATE BUSINESS

17. Father's Name (First, Middle, Last): CHESTER L. JOHNSON, SR.
18. Mother's Name (First, Middle, Maiden Surname): ELLAREE MORANT

19a. Informant's Name/Relationship (Type, Print): ELLAREE JOHNSON / MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1648 SHERWOOD ROAD BALTIMORE, Md 21239

20a. Method of Disposition: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): ARBUTUS MEMORIAL Park
Date: 12/29/97
20c. Location - City or Town, State: ARBUTUS, MARYLAND

21. Signature of Funeral Service Licensee: Gary Harris
22. Name and Address of Facility: CHATMAN - HARRIS F. H. 5240 REISTERSTOWN ROAD BALTIMORE Md 21215

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. MULTIPLE STABBINGS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year): 12 25 97
28b. Time of Injury: 4.05 AM
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred: SUBJECT WAS STABBED
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): HOUSE
28f. Location (Street and Number or Rural Route Number, City or Town, State): 1702 ASHBURTON ST. BALTIMORE MD

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marjorie McGrell
29c. License number: O.C.M.E
29d. Date signed (Month, Day, Year): DECEMBER 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARJORIE D. MCGRELL MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41070

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MYREE H. JONES

2. Date of Death (Month, Day, Year): DECEMBER 19 77

3. Time of Death: 0944

4a. Facility Name (If not institution, give street and number): Laurel Beltsville

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 439-36-5813

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 11-16-10

9. Birthplace (State or Foreign Country): MISSISSIPPI

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Laurel

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11385 Laurelwalk Drive

10f. Zip Code: 20708

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8 Years

College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Jessie W. Hopkins

18. Mother's Name (First, Middle, Maiden Surname): Pearlie Irby Hopkins

19a. Informant's Name/Relationship (Type, Print): Bonnie Cole - Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11385 Laurelwalk Drive Laurel, MD 20708

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): J.S. Clark Cemetery

Date: 12/28/97

20c. Location - City or Town, State: Monroe, LA

21. Signature of Funeral Service Licensee: John Evans

22. Name and Address of Facility: Sterling Ashton Funeral Home, Inc. 736 Edmondson Avenue Catonsville, MD 21228

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Respiratory - Cardiac Failure

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner stated.

29b. Signature and title of certifier: Walter Belleza M.D.

29c. License number: MD 46612

29d. Date signed (Month, Day, Year): 12-19-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Walter Belleza 575 Main Street, Suite 355 Laurel, MD 20707

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1998

32. Registrar's Signature: Linda Davidson-Randall

To be completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41071

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marguerite McKenna
2. Data of Daath — Month: December Dey: 30 Year: 1997
3. Time of Daath: 9:13 AM
4a. Facility Name *(If not institution, give street and numbar)*: Severna Park Center
4b. City, Town, or Location of Death: Severna Park
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 169-32-4677
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 06/16/1910
9. Birthplace *(State or Foreign Country)*: Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Pa.
10b. County: Montgomery
10c. City, Town or Location: Wynnewood
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 16 Meredith Road
10f. Zip Code: 19096
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grada complated)*: Elementary/Secondary (0-12): 2 years; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa retired)*: Accountant
16b. Kind of Business/Industry: Federal Government

17. Father's Nama *(First, Middle, Last)*: John South
18. Mother's Name *(First, Middle, Maiden Surneme)*: Dorothy Brown

19a. Informant's Name/Relationship *(Type, Print)*: Dorothy Brown / Daughter
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 16 Meredith Road Wynnewood, Pennsylvania 19096

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Calvary Cemetery
Date: 1/2/98
20c. Location - City or Town, State: Media, Pa. 19063

21. Signature of Funeral Service Licensee: David J. Weber
22. Name and Address of Facility: David J. Weber Funeral Home, 401 S. Chester Street Baltimore, Maryland 21231

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do nof enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failura. Lest only one cause on aach line.

Approximate Interval Between Onsel and Daath

Immediate Cause (Final diseasa or condition resulting in death): a. Sepsis — 1 week

Due to (or as a consequenca of): b. Infected Decubitus Ulcer — 3 Months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last

Due to (or es e consequenca of): c.

Due to (or as e consequance of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior fo completion of causa of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaicien:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner es stated. 2☐ **Medical Exeminer:** On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at the time, date end piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Wlynne MD Attending Doctor
29c. License number: D21684
29d. Data signed *(Month, Dey, Year)*: 1-7-98

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): C.V. CYRIAC. M.D 8109 RITCHIE HWY, PASADENA, MD 21122

State Registrar

31. Date filed *(Month, Day, Yeer)*: JAN 14 1998
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
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Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41072

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Stevenson

2. Date of Death (Month, Day, Year): December 29, 1997

3. Time of Death: 7:30 AM

4a. Facility Name (If not institution, give street and number): 703 Seabrook Ct.

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212-05-8045

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb.16,1918

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Baltimore

10c. City, Town or Location: Towson

10d. Inside City Limits: 1☐ Yes 2☒ No

10a. Street and Number: 703 Seabrook Ct.

10f. Zip Code: 21286

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse

16b. Kind of Business/Industry: Nursing

17. Father's Name (First, Middle, Last): James Mitchell

18. Mother's Name (First, Middle, Maiden Surname): Anna Estelle Shallenberger

19a. Informant's Name/Relationship (Type, Print): Angela Geilfuss - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 703 Seabrook Ct., Towson, MD 21286

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Baltimore/Wash.Crematory

Date: Jan.3,1998

20c. Location - City or Town, State: Laurel, MD

21. Signature of Funeral Service Licensee: Bryan W Clary Bryan W. Clary

22. Name and Address of Facility: Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure — Due to (or as a consequence of): — 1yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

diabetes mellitus

AS CVD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Edward P Costlow MD.

29c. License number: D19503

29d. Date signed (Month, Day, Year): December 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward Costlow, MD 10 Gerard Avenue, suite 214, Timonium, MD 21093

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41073

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY J. SIEKIERSKI

2. Date of Death (Month, Day, Year): DECEMBER 26, 1997

3. Time of Death: 2:15 AM

4a. Facility Name (If not institution, give street and number): MARINER NURSING CENTER

4b. City, Town, or Location of Death: BELAIR

4c. County of Death: HARFORD CO.

Funeral Director

5. Social Security Number: 215-05-4114

8. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7-22-14

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 617 S. KENWOOD AVENUE

10f. Zip Code: 21224

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 6 YEARS; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SEAMSTRESS

16b. Kind of Business/Industry: GALLANT BELT CO.

17. Father's Neme (First, Middle, Last): WILLIAM JAROMIN

18. Mother's Name (First, Middle, Malden Surname): MARY A. WOZNIAK

19a. Informant's Name/Relationship (Type, Print): MR. RICHARD SIEKIERSKI

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1117 PEACHTREE BELAIR, MARYLAND 21047

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): ST. STANISLAUS CEM.

Dete: 12-29

20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Charles R. Kaczorowski

22. Neme and Address of Facility: KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVENUE BALTO. MD. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart feilure. List only one cause on each line.

Approximete Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in deeth)
a. CONGESTIVE HEART FAILURE — 1 DAY

Due to (or es a consequence of):
b.

Sequenfially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Last
Due to (or es e consequence of):
c.

Due to (or es a consequence of):
d.

Part II. **Other significent conditions** contributing to death buf not resulting in the underlying ceuse given in Part I.

RHEUMATOID ARTHRITIS.
ASPIRATION PNEUMONIA
URINARY TRACT INFECTION.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was cese referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpetient 3☐DOA; Other: 4☒Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) and manner as stated. 2☐Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: ▶ Andrew Nowakowski MD

29c. License number: D 058096

29d. Date signed (Month, Day, Year): DECEMBER 30, 1997

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): ANDREW NOWAKOWSKI, MD 125 N. MAIN ST. BEL AIR, MD 21014

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1998

32. Registrar Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41074

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Wayne Wallander
2. Date of Death Month Day Year: Nov. 29, 1997
3. Time of Death: 4:00 P.M.
4a. Facility Name (If not institution, give street and number): Montgomery General Hosp.
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 459-40-2385
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 67 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 22, 1930
9. Birthplace (State or Foreign Country): Wichita Falls TX.

Usual Residence of Decedent

10a. State: OK
10b. County: N/A
10c. City, Town or Location: Tulsa
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 66 Highway
10f. Zip Code: N/A
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman
16b. Kind of Business/Industry: Sales

17. Father's Name (First, Middle, Last): Steven Ferrell Wallander
18. Mother's Name (First, Middle, Maiden Surname): Mattie Irene Reynolds

19a. Informant's Name/Relationship (Type, Print): Sandy Buckstein
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2426 W. Minister Dr. Olney, MD. 20832

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Floral Haven Mem. Gardens
Date: Dec. 5 1997
20c. Location - City or Town, State: Broken Arrow OK.

21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.
22. Name and Address of Facility: Skarda F.H. 2829 Hudson St. Balto., MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	9 Days
Due to (or as a consequence of): b.	Bronchogenic Carcinoma	1 month
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Cerebral Vascular Accident	2 weeks
Due to (or as a consequence of): d.	Chronic Obstructive Pulmonary Disease	10 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

28. Place of Death (Check only one): Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jay Weiner MD
29c. License number: 024591
29d. Date signed (Month, Day, Year): November 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jay Weiner MD 11501 Georgia Ave Wheaton, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 14 1998
32. Registrar's Signature:

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41075

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: WAYNE HOWARD ANDERSON

2. Dete of Deeth — Month: December; Dey: 24; Year: 1997

3. Time of Death: 11:40 AM

4a. Facility Neme *(If not institution, give street and number)*: 39 Bramble Lane

4b. City, Town, or Location of Death: Churchville

4c. County of Death: Harford

Funeral Director

5. Sociel Security Number: 169-22-6570

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Yeer)*: Sept. 10, 1927

9. Birthplece *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Churchville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 39 Bramble Lane

10f. Zip Code: 21028

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No — If Yes, Give Yeer or Dates: WWII

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12); College (1-4or 5+): 2

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Data Processing Supervisor

16b. Kind of Business/Industry: U.S. Government

17. Father's Neme *(First, Middle, Lest)*: Walter Franklin Anderson

18. Mother's Neme *(First, Middle, Melden Surneme)*: Emma (u/k) Jennings

19a. Informant's Neme/Reletionship *(Type, Print)*: Mina C. Anderson, wife

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 39 Bramble Lane, Churchville, Maryland 21028

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donation 5☐Other *(Specify)*

20b. Placa of Disposition *(Name of cemetary, cremetory or othar place)*: Harford Memorial Gardens — Dete: 12/29/97

20c. Location - City or Town, Stete: Aldino, Maryland

21. Signature of Funeral Service Licensee: Howard K. McComas

22. Nama end Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death)

a. Metastatic Poorly Differentiated Carcinoma - Primary of Pancreatic Origin — 1 month

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet Initiated events resulting in deeth) Last

b.

Due to (or es e consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contributa to the cause of death? 1☐Yee 2☐No 3☐Probably 4☒Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1☐Yes 2☐No

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

25. Wes case referred to medical exeminer? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 8☐Other *(Specify)*

27. Mamner of Death: 1☐Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending invastigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examinar:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end piece, end due to the cause(s) end menner stated.

29b. Signature end title of certifier: David M Hale

29c. License number: D20396

29d. Dete signed *(Month, Dey, Yeer)*: December 30, 1997

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print): David M. Hale 5807 Loch Raven Blvd Balt MD 21239

State Registrar

31. Dete filed *(Month, Day, Yeer)*: DEC 31 1997

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41076

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rose Regina Burch

2. Date of Death Month Day Year: December 31, 1997

3. Time of Death: 8:10 AM

4a. Facility Name *(If not institution, give street and number)*: St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 217-80-7412

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: December 27, 1940

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Mechanicsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 38959 Foley-Mattingly Road

10f. Zip Code: 20659

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cook

16b. Kind of Business/Industry: Retirement Home

17. Father's Name *(First, Middle, Last)*: Charles Stuart Morris

18. Mother's Name *(First, Middle, Maiden Surname)*: Ruth Alma Brown

19a. Informant's Name/Relationship *(Type, Print)*: Lewis Daniel Burch/Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 38959 Foley-Mattingly Rd., Mechanicsville, MD 20659

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Charles Memorial Gardens

Date: 1/3/1998

20c. Location - City or Town, State: Leonardtown, MD

21. Signature of Funeral Service Licensee: Michael K Gardiner

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O.Box 270, Leonardtown, MD 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Probable Myocardial Infarction — 5 hrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: —

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred: —

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: —

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: —

29a. Certifier *(Check only one)*: ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William Boyd MD

29c. License number: D14285

29d. Date signed *(Month, Day, Year)*: 1-5-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Boyd, II MD Leonardtown, MD 20650

State Registrar

31. Date filed *(Month, Day, Year)*: JAN -6 1998

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

9

97 41077

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rebecca Lynette Beaman			2. DATE OF DEATH (Month, Day, Year): December 22 1997	3. TIME OF DEATH: 12:41AM M
4. SOCIAL SECURITY NUMBER: 561-28-4897	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 22, 1921	8. BIRTHPLACE (State or Foreign Country): Iowa
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Mt. Airy	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7746 Emerson Burrier Rd.		10f. ZIP CODE: 21771	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): typist	16b. KIND OF BUSINESS/INDUSTRY: clerical
17. FATHER'S NAME (First, Middle, Last): Arthur Beaman		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rebecca Campbell	
19a. INFORMANT'S NAME (Type/Print): Delma Lucas		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7746 Emerson Burrier Rd. Mt. Airy, MD 21771	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Carroll Cremation, Inc. 12/23	20c. LOCATION — City or Town, State: Hampstead, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Catharine D. Hartzler		22. NAME AND ADDRESS OF FACILITY: Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebrovascular Accident	1 wk
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Previous cerebrovascular Disease

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Allen J. Gilson MD	29c. LICENSE NUMBER: D26516	29d. DATE SIGNED (Month, Day, Year): ▶ DEC 22 1997

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Allen J. Gilson MD 1475 TANEY AVE FRED MD 21702

31. DATE FILED (Month, Day, Year): DEC 30 1997	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41078

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Eileen Elizabeth Burns

2. Date of Death Month / Day / Year: December 24 1997

3. Time of Death: 3:55AM

4a. Facility Name *(If not institution, give street and number)*: 10609 High Beach Ct.

4b. City, Town, or Location of Death: New Market

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 216-12-6666

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 21, 1920

9. Birthplace *(State or Foreign Country)*: Wisconsin

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: New Market

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10609 High Beach Ct.

10f. Zip Code: 21774

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: John McDill Fox

18. Mother's Name *(First, Middle, Maiden Surname)*: Elsa Sonomon

19a. Informant's Name/Relationship *(Type, Print)*: Elizabeth E. Hunter/ daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10609 High Beach Ct. New Market, MD 21774

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Peter's Cemetery

Date: 12/29/97

20c. Location - City or Town, State: Libertytown, MD

21. Signature of Funeral Service Licensee: Catharine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home, 11802 Liberty Rd. Libertytown, MD 21762

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	6 months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Stroke	3 weeks
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D 41866

29d. Date signed *(Month, Day, Year)*: December 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): KANAN HUDHUD, MD 801 Tollhouse Ave, D3 Frederick, MD 21701

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41079

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lee Barker JR.

2. Date of Death Month Dey Yeer: 12-25-97

3. Time of Death: 0940

4e. Facility Name (If not institution, give street and number): 2470 Cullison Drive

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 224-03-8778

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 28 1916

9. Birthplace (State or Foreign Country): Virginia

Usuel Residence of Decedent

10a. State: Md.

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 2470 Cullison Drive

10f. Zip Code: 21157

10g. Citizen of Whet Country?: USA

11. Mantel Status: 1 [ ] Never Merried 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American indien, Bleck, Whita, atc. Specify: white

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): custodian

16b. Kind of Business/Industry: Public Schools

17. Fathar's Name (First, Middle, Last): Lee Barker

18. Mother's Neme (First, Middle, Meidan Sumama): Riddle

19e. Informent's Neme/Relationship (Type, Print): Palmer T. Barker (son)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 2470 Cullison Dr. Westminster, Md. 21157

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Remeval from State 4 [ ] Donetion 5 [ ] Othar (Specify)

20b. Pleca of Disposition (Nema of cemetery, crematory or other piace): Lee Memorial Gardens

Data: 12-29-97

20c. Location - City or Town, Stele: Woodway, Va.

21. Signature of Funerel Servica Licansee: Brian L. Haight

22. Name end Address of Fecility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart failure. List only one cause on eech line.

Approximata Interval Between Onset and Death

Immadiete Ceuse (Finel diseese or condition resulting in deeth)

e. UREMIA — 5 mo

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

b. Congestive Heart Jailure — 2 years

Due to (or es e consequenca of):

c.

Dua to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings avelleble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one) Hospital: 1 [ ] inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Menner of Deeth: 1 [ ] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, ferm, street, factory, office building, etc. (Spacify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end piece, and due to the ceuse(s) end menner as steted. 2 [ ] **Medical Examiner:** On the besis of examination end/or investigation, in my opinion, death occurred et the time, date end piace, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: Chitraketu Nagarur

29c. License number: D18200

29d. Dala signad (Month, Day, Year): 12/26/97

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): CHITRAKETU NAGARUR MD 700-A poole Rd westminster MD 21157

State Registrar

31. Date filed (Month, Dey, Yeer): DEC 29 1997

32. Registrer's Signeture: Julia Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41080

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NETTIE MADELINE BURT
2. Date of Death Month / Day / Year: DECEMBER 31, 1997
3. Time of Death: 8:45 A
4a. Facility Name *(If not institution, give street and number)*: 5509 BELVA PLACE
4b. City, Town, or Location of Death: LANHAM
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 579-26-3546
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: MAY 15, 1913
9. Birthplace *(State or Foreign Country)*: WASHINGTON DC

Usual Residence of Decedent

10a. State: MD
10b. County: PRINCE GEORGES
10c. City, Town or Location: LANHAM
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5509 BELVA PLACE
10f. Zip Code: 20706
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER
16b. Kind of Business/Industry: DOMESTIC

17. Father's Name *(First, Middle, Last)*: EUGENE TILGHMAN
18. Mother's Name *(First, Middle, Maiden Surname)*: PHEOBE SPENCER

19a. Informant's Name/Relationship *(Type, Print)*: RITA DIANE GOODALL/DAUGHTER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5509 BELVA PLACE LANHAM, MD, 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: HARMONY MEM. PARK
Date: 1-3-98
20c. Location - City or Town, State: LANDOVER, MD

21. Signature of Funeral Service Licensee: Regis J. Mahon
22. Name and Address of Facility: STERLING FUNERAL SVC, WASHINGTON DC

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. metastatic lung carcinoma — 1 YRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ira Dubner
29c. License number: MD D43028
29d. Date signed *(Month, Day, Year)*: December 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): I. DAVID SHOCKET, M.D. 106 IRVING ST, NW WASHINGTON, DC 20010

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 02 1998
32. Registrar's Signature: Julia Strickler-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41081

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Meriam B. Bush

2. Deta of Deeth — Month: December Day: 16 Year: 1997

3. Time of Death: 5:30 a.m.

4a. Facility Name (If not institution, giva street and number): 4740 Jacksonville Road

4b. City, Town, or Location of Death: Crisfield

4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 472-10-7542

6. Sex: 1☐M 2☒F

7. Aga (In yrs. last birthday): 89 Yrs. — If Undar 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): JAN. 1, 1908

9. Birthplace (State or Foreign Country): MINNESOTA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: PRINCE GEORGE'S

10c. City, Town or Location: RIVERDALE

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 6307 47TH AVENUE

10f. Zip Code: 20737

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐Never Married 2☐Merried 3☐Widowed 4☒Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Giva Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No Specify:

14. Race - American indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): PERSONNEL CLERK

16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Fether's Name (First, Middla, Last): NELS J. BENSON

18. Mothar's Nema (First, Middla, Maiden Sumama): JENNIE LARSON

19a. Informant's Name/Relationship (Type, Print): SIGNE ANN THRIFT, DAUGHTER

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 3502 LANCER DRIVE, HYATTSVILLE, MD 20782

20a. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or othar place): FORT LINCOLN CEMETERY

Date: 12/20/97

20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: Doris L. Grant

22. Neme end Addrass of Facility: FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediate Cause (Final disaase or condition resulting in deeth) e. Cerebro vascular Accident

Due to (or es a consequence of): Atrial Fibrillation

Sequentially list conditions, If any, leading to immediata cause. Enter Underlying Cause (Disease or injury thet initiated avents resulting in deeth) Last

b.

Due to (or es a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yee 2☒No 3☐Probably 4☐Unknown

24a. Was en autopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings svaliable prior to completion ot cause of death? 1☐Yas 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Piece of Deeth (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Homa 5☒Rasidence 6☐Other (Specify)

27. Mennar of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) and manner es steted. 2☐**Medical Examinar:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signeture and titla of cartifiar: [signature]

29c. License number: D 45098

29d. Date signed (Month, Dey, Year): DECEMBER 26, 1997

30. Neme end eddress ot person who completed cause of death (item 23e) (Type, Print): DR. VIJAY KARUMBUNATHAN 201 HALL HIGHWAY CRISFIELD, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

7

State Registrar

31. Dete filed (Month, Dey, Year): DEC 29 1997

32. Registrar's Signature: Jakie Davidson-Randall

DHMH 16 Rav 6/95

97-7408-033
B.K.S

CLINTON J. BAPTISE
Items:23a part I,27,28a-f per MEO G-757 3/11/98 dh

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41082

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLINTON JOSEPH BAPTISTE

2. Date of Death (Month, Day, Year): DEC. 23, 1997

3. Time of Death: 0610 AM

4a. Facility Name *(If not institution, give street and number)*: 10603 LAZY DAY LANE

4b. City, Town, or Location of Death: MITCHVILLE

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 101-64-5710

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 17 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: SEPT 22,1980

9. Birthplace *(State or Foreign Country)*: BRONX NY

Usual Residence of Decedent

10a. State: MD

10b. County: P.G. COUNTY

10c. City, Town or Location: MITCHELLVILLE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 10603 LAZY DAY LANE

10f. Zip Code: 20721

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 9 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: UNEMPLOYED

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: FITZ N. BAPTISTE

18. Mother's Name *(First, Middle, Maiden Surname)*: UNKNOWN

19a. Informant's Name/Relationship *(Type, Print)*: FITZ N.BAPTISTE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10603 LAZY DAY LANE MITCHELLVILLE MD 20721

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: HARMONY MEM PARK

Date: 1-2-98

20c. Location - City or Town, State: LANDOVER MD

21. Signature of Funeral Service Licensee: ▶ Alex S. Pope R

22. Name and Address of Facility: ALEXANDER S.POPE FUNERAL HOMES 2617 PENN. AVE S.E. WASHINGTON DC 20020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immedlete Ceuse (Final disease or condition resulting in deeth)
a. ENCARCERATED BOWEL

Due to (or es e consequence of):
b. ADHESIONS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. REMOTE STAB WOUND TO TORSO

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an eutopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? [X] Yes 2 [ ] No

26. Piece of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Neturaf 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Day Year)*: 12/13/96

28b. Time of Injury: unknown M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: subject stabbed

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: home

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 10603 Lazy Day Lane, Largo, Md.

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, end due to the cause(s) and menner as stated. [X] **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: ▶ Wayne Shelton M.D.

29c. License number: O.C.M.E

29d. Date signed *(Month, Day, Year)*: DEC. 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MD Expires & Records 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997

32. Registrar's Signature: Tabi Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

To Be Completed by Funeral Director

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41083

Reg. No.

4 0/4

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FOSTER BELFORD
2. Date of Death — Month: December Day: 28, Year: 1997
3. Time of Death: 7:30AM
4a. Facility Name (If not institution, give street and number): LAUREL REGIONAL HOSPITAL
4b. City, Town, or Location of Death: LAUREL
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 578-14-1698
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 77 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 8, 1920
9. Birthplace (State or Foreign Country): Wash.,D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Temple Hills
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2207 Afton Street
10f. Zip Code: 20748
10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 41-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Dept. of the Army

17. Father's Name (First, Middle, Last): Jonas Belford
18. Mother's Name (First, Middle, Maiden Surname): Annie Jordon

19a. Informant's Name/Relationship (Type, Print): Annie Belford - Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2207 Afton St., Temple Hills, Maryland 20748

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Lincoln Memorial Cemetery — Date: 1/3/98
20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: Alex S Pope Jr
22. Name and Address of Facility: ALEXANDER S. POPE FUNERAL HOMES 2617 Pennsylvania Avenue, SE DC 20020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. CARDIO RESPIRATORY FAILURE

Due to (or as a consequence of):
b. CARDIAC ARREST

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. HYPERTENTION

Due to (or as a consequence of):
d. DEMENTIA

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): NA
28b. Time of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how Injury occurred: NA
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): NA
28f. Location (Street and Number or Rural Route Number, City or Town, State): NA

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D 42019
29d. Date signed (Month, Day, Year): DEC 29TH 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): IMRAN CHOUDHURY 7350 VAN DUSEN RD SUITE 220, LAUREL MD 20707

31. Date filed (Month, Day, Year): DEC 31 1997
32. Registrar's Signature: Julia Thurston-Randall

State Registrar

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 41084

Certificate of Death

Reg. No.

Bedow, Philomena Loretta

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Philomena Loretta Beddow
2. Date of Death (Month, Day, Year): December 30, 1997
3. Time of Death: 2:13AM
4a. Facility Name (If not institution, give street and number): Doctors Community Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 174-50-8806
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 20, 1911
9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Seabrook
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 9416 Jones Place
10f. Zip Code: 20706
10g. Citizen of What Country?: United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Theodore Klusman
18. Mother's Name (First, Middle, Maiden Surname): Philomena Flutter

19a. Informant's Name/Relationship (Type, Print): Carol Beenick /Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9416 Jones Place, Seabrook, Maryland 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Saint Joseph Cemetery | Date: January 3, 1998
20c. Location - City or Town, State: Ashland, Pennsylvania

21. Signature of Funeral Service Licensee: Howard A Carson #M00690
22. Name and Address of Facility: Robert McDonald Funeral Home, 403 West Main Street, Girardville, PA 17935

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia — 2 days
Due to (or as a consequence of):
b. aspiration — 2days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Senile dementia — years
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: None

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Peter M Schissler MD
29c. License number: D22780
29d. Date signed (Month, Day, Year): 12/30/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter M Schissler MD 7500 Greenway Ctr Dr. Greenbelt Md 20770

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997
32. Registrar's Signature: Julia Anderson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41085

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOSHIA GLOVER BENNETT

2. Date of Death (Month, Day, Year): December 28, 1997

3. Time of Death: 2:58AM

4a. Facility Name (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 579-32-8460

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MARCH 28, 1923

9. Birthplace (State or Foreign Country): SUMTER COUNTY, SC

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: PRINCE GEORGE'S

10c. City, Town or Location: CAPITOL HEIGHTS

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5802 BALSAM ST.

10f. Zip Code: 20743

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: PVT.- OWN HOME

17. Father's Name (First, Middle, Last): PAUL GLOVER

18. Mother's Name (First, Middle, Maiden Surname): REBECCA HAILE

19a. Informant's Name/Relationship (Type, Print): KATHERINE McCRAY / DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5802 BALSAM ST. CAPITOL HTS., MD 20743

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MARYLAND NATIONAL CEM.

Date: 1-3-98

20c. Location - City or Town, State: LAUREL, MARYLAND

21. Signature of Funeral Service Licensee: Leonard L. Braxton

22. Name and Address of Facility: MARSHALL'S FUNERAL HOME OF MD 4308 SUITLAND RD. SUITLAND, MARYLAND 20746

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Hemorrhagic cerebrovasular accident

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Cerebral edema

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: L. Bahadori

29c. License number: D47928

29d. Date signed (Month, Day, Year): 12/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): LILA M. BAHADORI 3001 HOSPITAL DR. CHEVERLY, MD 20785

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

4

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997

32. Registrar's Signature: Julia Strachan-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41086

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALBERTUS A. BAGLEY, SR.

2. Date of Death (Month, Day, Year): DECEMBER 20, 1997

3. Time of Death: 8:15pm

4a. Facility Name (If not institution, give street and number): MARINER HEALTH AT CIRCLE MANOR

4b. City, Town, or Location of Death: KENSINGTON

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 544-14-5927

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): AUG. 25, 1915

9. Birthplace (State or Foreign Country): PALATKA, FLA.

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: MONTGOMERY

10c. City, Town or Location: KENSINGTON

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 10231 CARROLL PLACE

10f. Zip Code: 20895

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Year or Dates: 8Jun45 9SEP45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CLERK

16b. Kind of Business/Industry: DEPT. OF DEFENSE

17. Father's Name (First, Middle, Last): SAMUEL BAGLEY

18. Mother's Name (First, Middle, Maiden Surname): MAY SCARBOROUGH

19a. Informant's Name/Relationship (Type, Print): ARDELL BAGLEY/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4420 ALABAMA AVE. S.E. WASHINGTON D.C. 20019

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): FT. LINCOLN CEMETERY

Date: 12/26

20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: Juawara L. Braxton

22. Name and Address of Facility: MARSHALL'S FUNERAL HOME 4308 SUITLAND ROAD SUITLAND, MD 20746

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Colon Carcinoma — Approximate Interval: 1 year

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jeanne P. Asher MD

29c. License number: D 34032

29d. Date signed (Month, Day, Year): 12/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JEANNE P. ASHER MD 3720 FARRAGUT AVE. KENSINGTON, MD

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997

32. Registrar's Signature: Julia Thurston-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41087

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET ELIZABETH BOYLE

2. Date of Death (Month, Day, Year): DECEMBER 27 1997

3. Time of Death: 1:35 PM

4a. Facility Name *(If not institution, give street and number)*: SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 215-20-7372

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT 31 1922

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 45 WEMPE DRIVE

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ALLEGANY CO. BOARD OF EDUCATION

16b. Kind of Business/Industry: CAFETERIA MANAGER

17. Father's Name *(First, Middle, Last)*: GEORGE WALTER GEATZ

18. Mother's Name *(First, Middle, Maiden Surname)*: EMMA O'NEILL

19a. Informant's Name/Relationship *(Type, Print)*: RICHARD F. BOYLE HUSBAND

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 45 WEMPE DRIVE CUMBERLAND MARYLAND 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ROCKY GAP CEMETERY

Date: DEC 30 1997

20c. Location - City or Town, State: RFD FLINTSTONE MD.

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. LUNG CANCER PLEURAL EFFUSION — 3 WEEKS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Brain Cancer
pulmonary Emphysema
atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: X Renato Espina, MD

29c. License number: D 03459

29d. Date signed *(Month, Day, Year)*: DECEMBER 29 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR RENATO R. ESPINA 902 SETON DRIVE CUMBERLAND MARYLAND 21502

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10
mlf

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41088

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM KENNETH BAISOR

2. Data of Daath — Month: DEC. Day: 30, Year: 1997

3. Tima of Death: 12:15 a.m.

4a. Facility Nama (If not institution, giva street and number): MORAN MANOR NURSING HOME

4b. City, Town, or Location of Death: WESTERNPORT

4c. County of Death: ALLEGANY

Funeral Director

5. Social Sacurity Number: 178-07-6001

6. Sex: 1 [X] M 2 [ ] F

7. Aga (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Yaar): Sept.15,1910

9. Birthplaca (Stata or Foraign Country): Penn

To Be Completed by Funeral Director

Usual Rasidence of Decadant

10a. Stata: WV

10b. County: Mineral

10c. City, Town or Location: Keyser

10d. Inside City Limits: 1 [X] Yas 2 [ ] No

10e. Street and Number: 345 HAWTHORNE ROAD

10f. Zip Coda: 26726

10g. Citizan of What Country?: U.S.A.

11. Marital Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decadant Ever in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No — If Yas, Giva Yaer or Datas: WW II

13. Wes Decadent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Raca - Amarican Indian, Black, Whita, etc. Specify: WHITE

15. Decadant's Education (Specify only highast grada compiatad): Elamentary/Secondary (0-12): — College (1-4or 5+): 3

16a. Decadent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): ENGINEER

16b. Kind of Businass/Industry: CONSTRUCTION

17. Fathar's Nama (First, Middla, Last): HARVEY BUSH BAISOR

18. Mothar's Nama (First, Middla, Maidan Surname): MARY JANE YOUNG

19a. Informant's Name/Relationship (Type, Print): MARY EVELYN BAISOR (WIFE)

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 345 HAWTHORNE ROAD, KEYSER, WEST VIRGINIA 26726

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar (Specify)

20b. Placa of Disposition (Nama of cematary, cremetory or othar piaca): POTOMAC MEM. GARDENS — Data: 1/03/98

20c. Location - City or Town, Stata: KEYSER, WEST VIRGINIA

21. Signatura of Funaral Service Licensee: Harold Dean Rosenberger

22. Nama and Address of Facility: MARKWOOD McKENZIE FUNERAL HOME P.O. Box 912, KEYSER, WV 26726

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complicetions that caused tha deeth. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

		Approximate Interval Between Onsat and Death
Immediata Cause (Finel disaasa or condition rasulting in death) e.	Congestive Heart failure	unknown
Dua to (or as a consequence of):	COPD	Unknown
Sequantially list conditions, if any, leading to immedieta causa. Entar Underlying Cause (Disease or injury thet initiated avants rasulting in daath) Last — b.		
Dua to (or as a consequance of): c.	Non insulin dependent D. M.	unknown
Dua to (or as a consequance of): d.	multiple infarct dementia	unknown

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.: Pseudomembranous colities; osteo arthritis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? NO 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to compiation of cause of death? 1 [ ] Yas 2 [ ] No

25. Was case referred to medical examinar? 1 [ ] Yas 2 [X] No

28. Placa of Death (Check only ona) — Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [X] Nursing Homa 5 [ ] Rasidance 6 [ ] Othar (Specify)

27. Mannar of Daath: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding invastigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Day, Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Spacify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To tha best of my knowledga, deeth occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 [ ] Medical Examiner: On tha basis of axamination and/or invastigation, in my opinion, daeth occurred at the tima, date and piece, end due to the cause(s) and mannar stated.

29b. Signatura and titla of cartifiar: [signature]

29c. Licensa number: D-40182

29d. Data signed (Month, Day, Yaar): 1/2/98

30. Nama and addrass of person who completed cause of daath (Item 23a) (Type, Print): DR. MAHESH B. SHROFF, M.D. 390 CARSKADON LANE, KEYSER, WV 26726

State Registrar

31. Data filad (Month, Day, Yaar): JAN 05 1998

32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6 yes

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41089

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marie Bridget Brandt

2. Date of Death Month Day Year: DECEMBER 26 1997

3. Time of Death: 9:40 PM

4a. Facility Name *(If not institution, giva street and number)*: MEMORIAL HOSPITAL & MEDICAL CENTER

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 216-22-5653

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 6, 1927

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Ellerslie

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10307 Mason Dixon View Street

10f. Zip Coda: 21529

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Nama *(First, Middle, Last)*: Patrick L. Manley

18. Mother's Name *(First, Middle, Maiden Surname)*: Helen C. (Burns)

19a. Informant's Name/Relationship *(Type, Print)*: Donald H. Brandt-husband

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, State, Zip Code)*: Box 212-10307 Mason Dixon Ellerslie MD 21529

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or othar place)*: Sunset Memorial Park

Date: 12/30

20c. Location - City or Town, State: Cumberland MD

21. Signature of Funeral Service Licensee: ▶ James J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland MD 21502

Physician /Medical Examiner

23a. Part I. Entar tha disease, or complications that causad the death. Do not enter the mode ot dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina.

		Approximate Interval Between Onset and Death
Immadiate Cause (Finat disaase or condition resulting in death) a.	HEPATIC FAILURE	3 MONTHS
Due to (or as a consequenca of):		
b.	METASTATIC CARCINOMA OF LUNG	18 MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Dua to (or as a consequenca of): d.		

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Waa an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatiant 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time ot Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, tactory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and menner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title ot certitier: ▶ William Lamm MD

29c. License number: D 25406

29d. Date signad *(Month, Day, Year)*: JANUARY 2, 1998

30. Name and addresa of person who completed cause of death (Item 23a) (Type, Print): WILLIAM LAMM M.D., 47 VIRGINIA AVE., CUMBERLAND, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998

32. Registrar's Signature

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

MARIE BRANDT 216-22-5653

6

MS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41090

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Parker Jacob Beshore

2. Date of Death Month Dey Year: December 27, 1997

3. Time of Death: 1:20 PM

4a. Facility Name (If not institution, give street and number): Hart Heritage

4b. City, Town, or Location of Death: Street

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 168-14-0348

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 98 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 26, 1899

9. Birthplece (State or Foreign Country): Pennsylvania

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Harford

10c. City, Town or Location: Fallston

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 1905 Harford Road

10f. Zip Code: 20147

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Representative

16b. Kind of Business/Industry: Agriculture

17. Fether's Neme (First, Middle, Last): Jacob B. Beshore

18. Mother's Neme (First, Middle, Meiden Surneme): Dillia Mae Gross

19a. Informent's Neme/Reletionship (Type, Print): Samuel B. Foard

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 4425 Fawn Grove Rd., Street, MD 21154

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☒ Removel from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other plece): Centre Presbyterian Cem.

Dete: 12-31-97

20c. Location - City or Town, Stete: New Park, PA

21. Signature of Funeral Service Licensee: Howard K. McComas III

22. Neme end Address of Feclility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth): e. Congestive Heart Failure — 4YS

Due to (or es e consequence of): Hypertension — 4YS

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Lest:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: - Colon Obstruction

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No N/A

25. Wes case referred to medical exeminer? 1☐ Yes 2☐ No

26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) Assisted Living

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer): NA

28b. Time of Injury: NA M

28c. Injury et Work? 1☐ Yes 2☐ No NA

28d. Describe how injury occurred: NA

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify): NA

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Alfred D Spanos MD

29c. License number: D 39889

29d. Date signed (Month, Dey, Year): 12/29/97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): ALFRED D SPANOS 615 W. MACPHAIL RD BEL AIR MD 21014

State Registrar

31. Dete filed (Month, Day, Year): DEC 30 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41091

BOWERS, CATHERINE 12/26/97 1930

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Catherine Patricia Bowers
2. Date of Death: Month 12 Day 26 Year 1997
3. Time of Death: 19:30
4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 216-30-5580
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 03/09/1934
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 35 Paradise Road
10f. Zip Code: 21001
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owned Furniture Store
16b. Kind of Business/Industry: Retail

17. Father's Name (First, Middle, Last): Frederick McClintoch
18. Mother's Name (First, Middle, Maiden Surname): Almira Seyfriet

19a. Informant's Name/Relationship (Type, Print): Leonard J. Bowers- Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 35 Paradise Rd. Aberdeen, MD 21001

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): R.A. Ferris &Co. Inc.
Date: 12/29/97
20c. Location - City or Town, State: West Chester, PA

21. Signature of Funeral Service Licensee: George M. Hampton Jr.
22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington St. Havre de Grace, MD

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. GI Bleed — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hyponatremia
Aspiration pneumonia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier
29c. License number: D29339
29d. Date signed (Month, Day, Year): December 27, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): LINDA FRENCH 101 E Wheel Road Bel Air MD 21015

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41092

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): NAOMI LOUISE BILLINGS
2. Date of Death (Month, Day, Year): December 20, 1997
3. Time of Death: 9:55 A.M.
4a. Facility Name (If not institution, give street and number): 3040 James Run Road
4b. City, Town, or Location of Death: Aberdeen
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 242-36-3980
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 3, 1928
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3040 James Run Road
10f. Zip Code: 21001
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress
16b. Kind of Business/Industry: Restaurant
17. Father's Name (First, Middle, Last): James Frank Billings
18. Mother's Name (First, Middle, Maiden Surname): Bessie Mae Billings
19a. Informant's Name/Relationship (Type, Print): Mary E. Bowers, sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3040 James Run Road, Aberdeen, Maryland 21001
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Double Creek Baptist Ch. Cem. Date: 12/23/97
20c. Location - City or Town, State: Traphill, NC
21. Signature of Funeral Service Licensee: Howard K. McComas III
22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Chronic Obstructive Pulmonary Disease	ten years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mark P Wild MD
29c. License number: d35522
29d. Date signed (Month, Day, Year): December 22, 1997.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Mark Wild 2 North Avenue Bel Air Maryland 21014.

State Registrar

31. Date filed (Month, Day, Year): DEC 23 1997
32. Registrar's Signature: [illegible] Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41093

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEWIS FRANKLIN BROWN SR.

2. Date of Death: Month: December Day: 21 Year: 1997

3. Time of Death: 7:30 AM

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 236-64-6283

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 57 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan. 2, 1940

9. Birthplace (State or Foreign Country): W. Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Forest Hill

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2427 Rocks Road

10f. Zip Code: 21050

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Electrician

16b. Kind of Business/Industry: Refuse Disposal

17. Father's Name (First, Middle, Last): Guy (U/K) Brown

18. Mother's Name (First, Middle, Maiden Surname): Iona (U/K) Hollingsworth

19a. Informant's Name/Relationship (Type, Print): Patricia A. Brown - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2427 Rocks Road, Forest Hill, Maryland 21050

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bel Air Memorial Grdns. Date: 12-23-97

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Stephen A. Murphy

22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CHOLANGITIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. COMMON BILE DUCT OBSTRUCTION

Due to (or as a consequence of):

c. CARCINOMA OF PANCREAS WITH METASTASIS

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Thomas A. Magg

29c. License number: D 40966

29d. Date signed (Month, Day, Year): DEC 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VEDAPURISAN VISWANATHAN, MD

State Registrar

31. Date filed (Month, Day, Year): DEC 23 1997

32. Registrar's Signature: Judi Strickler-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Brown, Lewis Franklin

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41094

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Curtis Martin Barrett

2. Date of Death — Month: 12 Day: 21 Year: 1997

3. Time of Death: 18:52 Hrs

4a. Facility Name *(If not institution, give street and number)*: Harford Memorial Hospital

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-09-2164

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 04/23/1920

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Aberdeen

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 639 Aberdeen Thruway

10f. Zip Code: 21001

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1943-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Truck Driver

16b. Kind of Business/Industry: Construction

17. Father's Name *(First, Middle, Last)*: Samuel Martin Barrett

18. Mother's Name *(First, Middle, Maiden Surname)*: Molley Tracey

19a. Informant's Name/Relationship *(Type, Print)*: Dorothy Barrett- Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 639 Aberdeen Thruway, Aberdeen MD 21001

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: R.A. Ferris & Co. Inc.

Date: 12/22/97

20c. Location - City or Town, State: West Chester, PA

21. Signature of Funeral Service Licensee: George M. Hampton Jr

22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington St Havre de Grace, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Acute Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ASCVD

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*: NA

28b. Time of Injury: NA M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: NA

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*: NA

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: NA

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: DME

29c. License number: OCME

29d. Date signed *(Month, Day, Year)*: Dec 22nd 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): G.S.Prabhu M.D. 218 Fulford Avenue Bel Air MD.21014 410-879-6564

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 23 1997

32. Registrar's Signature: Barbara Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41095

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mildred Ellis Beverly
2. Date of Death (Month, Day, Year): December 16, 1997
3. Time of Death: 9:00 P.M
4a. Facility Name (If not institution, give street and number): Woodside Center
4b. City, Town, or Location of Death: Silverspring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-20-6671
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): August 03, 1926
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Dorchester
10c. City, Town or Location: Taylors Island
10d. Inside City Limits: 1☐ Yes 2☑ No
10e. Street and Number: 4336 Smithville Road
10f. Zip Code: 21669
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☑ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☑ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waitress
16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Hollie Ellis
18. Mother's Name (First, Middle, Maiden Surname): Henrietta Lee

19a. Informant's Name/Relationship (Type, Print): Deborah Pugh (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 100 Colwyn Terrace-Lansdale, Pa. 19446

20a. Method of Disposition: 1☑ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithville Cemetery
Date: 12/20/97
20c. Location - City or Town, State: Taylors Island, MD.

21. Signeture of Funeral Service Licensee: Janelle C. Henry
22. Name end Address of Facility: Henry Funeral Home 510 Washington St. Cambridge, MD. 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death): a. Metastatic Adenocarcinoma of Colon — 2 months

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest:

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Ascites
Pleural Effusions

23b. Did tobacco uee contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medicel examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury: M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, dete and piece, and due to the ceuse(s) and menner steted.

29b. Signature and title of certifier: [signature]
29c. License number: D 24886
29d. Date signed (Month, Dey, Year): 12/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark H. Ellis, MD 10801 Lockwood Dr. Silver Spring MD 20901

State Registrar

31. Date filed (Month, Dey, Year): JAN 6 1998
32. Registrar's Signature: [signature] Lawrence Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41096

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Susan M. Berman
2. Date of Death Month Day Year: 12/19/1997
3. Time of Death: 0925 AM
4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 084 03 5368
6. Sex: 1☐ M 2☒ F XX
7. Age *(In yrs. last birthday)*: 86 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 10/08/1911
9. Birthplace *(State or Foreign Country)*: New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No X
10e. Street and Number: 15115 Interlachen Drive #517
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married X 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No X — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No X *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12); College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Tutor
16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Abram Lipsky
18. Mother's Name *(First, Middle, Maiden Surname)*: Annie Rosenberg

19a. Informant's Name/Relationship *(Type, Print)*: Jules Berman (husband)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15115 Interlachen Drive #517/Silver Spring MD 20906

20a. Method of Disposition: 1☐ Burial 2☒ Cremation X 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Date: 12/20/97
20c. Location - City or Town, State: Alexandria VA

21. Signature of Funeral Service Licensee: ▶ M. William Nagger
22. Name and Address of Facility: Advent Funeral & Cremation Services, Annapolis MD 21401

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Interstitial pulmonary fibrosis — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Mahtab Chung M.D
29c. License number: D21615
29d. Date signed *(Month, Day, Year)*: December 20, 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Mahtab Chung, M.D. 3305 N. Leisure World Blvd. Silver Spring MD 20906

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 23 1997
32. Registrar's Signature: Gloria Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41097

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Sabine Elisabeth Dorothea Bosma
2. Date of Death Month / Day / Year: 12-24-97
3. Time of Death: 5:36 Am
4a. Facility Name *(If not institution, give street and number)*: 754 Trenton Ave
4b. City, Town, or Location of Death: Severna PK
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 100-30-8884
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 60 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 2-9-1937
9. Birthplace *(State or Foreign Country)*: Netherlands

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Severna Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 754 Trenton Ave.
10f. Zip Code: 21146
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4 or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Attorney
16b. Kind of Business/Industry: Law

17. Father's Name *(First, Middle, Last)*: Ommen Neuse
18. Mother's Name *(First, Middle, Maiden Surname)*: Rose Vickery

19a. Informant's Name/Relationship *(Type, Print)*: Wim Bosma / son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3107 White Ave, BALT, MD 21214

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Metro Crematory — Date: 12-26-97
20c. Location - City or Town, State: Catonsville MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: 495 Ritchie Hwy — Barranco and Sons Ser-PK, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Metastatic Non-Small-Cell Lung Cancer — 6 mos

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ASCVD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert C Dart Jr. MD
29c. License number: D 39660
29d. Date signed *(Month, Day, Year)*: 12-24-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Robert C. Dart, Jr. MD 901 E. Fort Ave. BALT, MD 21230

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41098

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FRANCIS XAVIER BREWIS, SR.

2. Date of Death (Month, Day, Year): DECEMBER 22, 1997

3. Time of Death: 9:30PM

4a. Facility Name *(If not institution, give street and number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 213-12-6273

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JULY 17, 1917

9. Birthplace *(State or Foreign Country)*: MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: FERNDALE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 210 SOUTH BROADVIEW BLVD.

10f. Zip Code: 21061

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SELF-EMPLOYED

16b. Kind of Business/Industry: TRUCKING

17. Father's Name *(First, Middle, Last)*: WILLIAM BREWIS

18. Mother's Name *(First, Middle, Maiden Surname)*: MABLE BUTLER

19a. Informant's Name/Relationship *(Type, Print)*: EVELYN E. BREWIS WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 210 SOUTH BROADVIEW BLVD. FERNDALE, MARYLAND 21061

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GLEN HAVEN MEMORIAL PARK

Date: 12/29/97

20c. Location - City or Town, State: GLEN BURNIE, MARYLAND

21. Signature of Funeral Service Licensee: Michael C. Taylor

22. Name and Address of Facility: SINGLETON FUNERAL HOME, P.A. 1 SECOND AVE. S.W. GLEN BURNIE, MARYLAND 21061

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Alzeimer's disease

Due to (or as a consequence of):

b. Parkinson Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA / Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Date of Injury *(Month, Day Year)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: YEONG OH, M.D. MD

29c. License number: 025654

29d. Date signed *(Month, Day, Year)*: 12/24/97

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Yeong Oh 142 Crain Hwy N GB MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41099

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CATHERINE SUE BORUM

2. Date of Death (Month, Day, Year): December 30, 1997

3. Time of Death: 1010

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 230-52-5790

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 24, 1942

9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WORCESTER

10c. City, Town or Location: POCOMOKE CITY

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3244 JOHNSON ROAD

10f. Zip Code: 21851

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DIETARY AIDE

16b. Kind of Business/Industry: NURSING HOME

17. Father's Name (First, Middle, Last): JAMES LESLIE BARLOW, SR.

18. Mother's Name (First, Middle, Maiden Surname): ELOUISE TAYLOR

19a. Informant's Name/Relationship (Type, Print): WILLIAM LEE BORUM/HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3244 JOHNSON ROAD, POCOMOKE CITY, MD 21851

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): FIRST BAPTIST CEMETERY

Date: 1/2/98

20c. Location - City or Town, State: POCOMOKE CITY, MARYLAND

21. Signature of Funeral Service Licensee: Lauren D. Zeller

22. Name and Address of Facility: ZELLER FUNERAL HOME, P. O. BOX 3171, 1212 OLD OCEAN CITY ROAD, SALISBURY, MD 21802

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory Failure — 3d

Due to (or as a consequence of):
b. Emphysema — 20yr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Cancer of lung — 1yr.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: R. Layton Jr

29c. License number: D13222

29d. Date signed (Month, Day, Year): 12/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. R. LAYTON 100 E. CARROLL PRMC SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year): JAN 5 1998

32. Registrar's Signature: Julia Dawson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Catherine S. Borum 230-52-5790

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41100

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): JAMES G. COAKLEY
2. Dete of Deeth — Month: Dec. Dey: 17 Yeer: 1997
3. Time of Death: 1:15AM
4e. Facility Neme (If not institution, give street and number): Physicians Memorial Hospital
4b. City, Town, or Location of Deeth: La Plata
4c. County of Deeth: Charles

Funeral Director

5. Social Security Number: 577-36-2820
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthdey): 69 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): SEPT. 18, 1928
9. Birthplece (State or Foreign Country): VIRGINIA

Usuel Residence of Decedent

10a. Stete: MARYLAND
10b. County: ST. MARY'S COUNTY
10c. City, Town or Location: CHARLOTTE HALL
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: BOX 5, ROUTE 2
10f. Zip Code: 20622
10g. Citizen of Whet Country?: UNITED STATES
11. Meritel Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indian, Bleck, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 11 — College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): CAB DRIVER
16b. Kind of Business/Industry: TRANSPORTATION
17. Fether's Neme (First, Middle, Last): VERNON GILBERT COAKLEY
18. Mother's Name (First, Middle, Meiden Surneme): MARGARET SLAYTON
19e. Informent's Neme/Reletionship (Type, Print): SALLY MEMMERT, DAUGHTER
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 6994 BEACHMONT DRIVE, SYKESVILLE, MD 21784
20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): FORT LINCOLN CEMETERY
Dete: 12/19/97
20c. Locetion - City or Town, Stete: BRENTWOOD, MARYLAND
21. Signeture of Funeral Service Licensee: Louis L. Hart
22. Neme end Address of Fecility: FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. CARDIAC ARRYTHMIA — FEW MINUTES
Due to (or es e consequence of):
Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initiated events resulting in deeth) Lest: b. COR PULMONALE — MONTHS
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Pert Ii. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.: ANXIETY DISORDER

23b. Did tobecco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probebly 4☐Unknown

24e. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐Yes 2☐No

25. Wes case referred to medical exeminer? 1☐Yes 2☒No

28. Place of Deeth (Check only one): Hospitel: 1☒Inpetient 2☐ER/Outpetient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Dey Yeer):
28b. Time of Injury: M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred:
28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify):
28f. Locetion (Street and Number or Rurel Route Number, City or Town, Stete):

29e. Certifier (Check only one): 1☒**Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted. 2☐**Medicel Exeminer:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier:
29c. License number: D-44436
29d. Dete signed (Month, Dey, Yeer): Dec. 27, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Ashvin J. Patel 6B Industrial Park Drive Waldorf, Maryland 20602

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 29 1997
32. Registrar's Signeture: Julia Anderson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

James Coakley
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41101

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ERNEST R. CLIFTON

2. Date of Death (Month, Day, Year): DECEMBER 17, 1997

3. Time of Death: 0020

4a. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: TAKOMA PARK

4c. County of Death: MONTGOMERY COUNTY

Funeral Director

5. Social Security Number: 409-26-4334

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): DEC. 24, 1920

9. Birthplace (State or Foreign Country): TENNESSEE

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: PRINCE GEORGE'S

10c. City, Town or Location: RIVERDALE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6004 GREENVALE PARKWAY

10f. Zip Code: 20737

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Giva Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): RESEARCH ANALYST

16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last): ERNEST R. CLIFTON

18. Mother's Name (First, Middle, Maiden Surname): SUSIE COTHRAN

19a. Informant's Name/Relationship (Type, Print): MARJORIE CLIFTON, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6004 GREENVALE PARKWAY, RIVERDALE, MARYLAND 20737

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): FORT LINCOLN CEMETERY

Date: 12/20/97

20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Address of Facility: FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicationa that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. POST TRAUMATIC INTRACRANIAL HEMORRHAGE — 16 DAYS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uee contribute to the cause of death? 1 [ ] Yas 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of causa of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only ona)

Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Data of Injury (Month, Dey Yeer): 12/1/97

28b. Time of Injury: 11:30A M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Dascribe how injury occurred: FELL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): SOAPS LAUNDRYMAT

28f. Location (Street and Number or Rural Route Number, City or Town, State): 7125 BALTIMORE AVE COLLEGE PARK, MARYLAND 20740

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D08546

29d. Date signed (Month, Day, Yaer): DECEMBER 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN TAUBER, M.D., 8218 WISCONSIN AVENUE, ROOM 318, BETHESDA, MARYLAND 20814

State Registrar

31. Date filed (Month, Dey, Year): DEC 29 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41102

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Antoneda Curey

2. Date of Death (Month, Day, Year): December 24, 1997

3. Time of Death: 10:07 PM

4a. Facility Name (If not institution, give street and number): Fort Washington Hospital

4b. City, Town, or Location of Death: Fort Washington

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 193-12-0761

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 12/16/1924

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Fort Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 8109 Carey Branch Drive

10f. Zip Code: 20744

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Benjamin Orzechowski

18. Mother's Name (First, Middle, Maiden Surname): Ann Juice

19a. Informant's Name/Relationship (Type, Print): Patricia A. Shoop/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1020 N. Larrimore St., Arlington, VA 22205

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cemetery

Date: 12/31/97

20c. Location - City or Town, State: Arlington, VA

21. Signature of Funeral Service Licensee: ▶ Faye P. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home, 6160 Oxon Hill Rd., Oxon Hill, MD 20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):

a. Cardiopulmonary Arrest

Due to (or as a consequence of):

b. SEVERE END STAGE STENOSIS DEGENERATIVE CHRONIC

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

d. ADULT ONSET (TYPE II) DIABETES MELLITUS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MS

29c. License number: MS-052359-L

29d. Date signed (Month, Day, Year): 29 DEC 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mark D. Goodwin, Family Practice Building, W. Perimeter Dr., Andrews A.F.B., MD

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997

32. Registrar's Signature: ▶ Julie Thurber Randall

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41103

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ANNIE MAE CRAIG

2. Date of Death Month / Day / Year: December 29 1997

3. Time of Death: 4:16 PM

4a. Facility Name *(If not institution, give street and number)*: Prince George's Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-32-6499

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 8, 1919

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Cheverly

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3404 Laurel Avenue

10f. Zip Code: 20785

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic Worker

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Charles H. Waddy

18. Mother's Name *(First, Middle, Maiden Surname)*: Gustavia Green

19a. Informant's Name/Relationship *(Type, Print)*: Jean E. Jones/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3404 Laurel Avenue, Cheverly, Maryland 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Harmony Memorial Park

Date: 01/03 1998

20c. Location - City or Town, State: Landover, Maryland

21. Signature of Funeral Service Licensee: ▶ Nancy A. Pencantie

22. Name and Address of Facility: J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA — 1-2 hours

Due to (or as a consequence of):

b. pulmonary EDEMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. RESPIRATORY DISTRESS

Due to (or as a consequence of):

d. FEMORAL STRESS pulmonary DISEASE

ADULT RESPIRATORY DISTRESS Syndrome — 1-2 days

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: hypoxemia, UTI, pneumothorax

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Samuel Allyne

29c. License number: D25766

29d. Date signed *(Month, Day, Year)*: 12/30/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Samuel Allyne, M.D., 7100 Baltimore Avenue, #510, College Park, Maryland 20740

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 31 1997

32. Registrar's Signature: Julia Thurston-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41104

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William McIndoe Craze
2. Date of Death Month Day Year: Dec 24 1997
3. Time of Death: 15:00
4a. Facility Name *(If not institution, give street and number)*: Egle Nursing Home
4b. City, Town, or Location of Death: Lonaconing
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 214-07-6956
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug 25 1917
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 612 Holland Street
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates: Korean & WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner/Operator
16b. Kind of Business/Industry: Cemetery

17. Father's Name *(First, Middle, Last)*: Thomas W. Craze
18. Mother's Name *(First, Middle, Maiden Surname)*: Edith Schuyler

19a. Informant's Name/Relationship *(Type, Print)*: Eleanor S. Craze , Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 612 Holland Street, Cumberland, MD 21502

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: Restlawn Mem. Gardens — Date: Dec 29,1997
20c. Location - City or Town, State: LaVale, MD 21502

21. Signature of Funeral Service Licensee: ▶ Douglas L. Hafer
22. Name and Address of Facility: Hafer Chapel of the Hills Mortuary 1302 National Hwy., LaVale,MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebral Vascular Accident	2 mos.
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. Generalized Arteriosclerosis	3 years
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus Type II

Dementia, Alzheimer's Type

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ L.R. Miles JR MD
29c. License number: D07004
29d. Date signed *(Month, Day, Year)*: Dec. 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): L.R. MILES, JR., M.D. 57 JACKSON ST. LONACONING MD. 21539

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997
32. Registrar's Signature: Gabi [illegible]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

10 1 VA 11 mlf

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41105

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: GEORGE LEWIS CULLUM

2. Date of Death Month Day Yeer: Dec. 18, 1997

3. Time of Deeth: 10:13 P.M.

4e. Facility Neme *(If not institution, give street end number)*: Harford Memorial Hospital

4b. City, Town, or Location of Deeth: Havre de Grace

4c. County of Deeth: Harford

Funeral Director

5. Social Security Number: 213-18-2413

6. Sex 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 17, 1918

9. Birthpiece *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits 1☐ Yes 2☒ No

10e. Street end Number: 105 Robinhood Road

10f. Zip Code: 21078

10g. Citizen of What Country?: USA

11. Maritel Status 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1944-1947

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bieck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16e. Decedent's Usuei Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic

16b. Kind of Business/Industry: Federal Government

17. Father's Name *(First, Middle, Last)*: George Alexander Cullum

18. Mother's Neme *(First, Middle, Maiden Surname)*: Minnie Jeminie Thompson

19a. Informant's Name/Relationship *(Type, Print)*: Michael G. Cullum - Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1275 Courtney Lane, Belcamp, Maryland 21017

20a. Method of Disposition 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Calvary UMC Cemetery

Dete: 12-22-97

20c. Location - City or Town, Stete: Churchville, Maryland

21. Signature of Funeral Service Licensee: Howard R. McComas

22. Neme end Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the diseses, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediete Cause (Final diseese or condition resulting in death)
e. Congestive heart failure

Due to (or as a consequence of):
b. Ischemic cardiomyopathy

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last

Due to (or as a consequence of):
c. Remnent MI

Due to (or es a consequence of):
d. COPD

Part II. **Othar significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

10 Diabetes mellatus
CVA

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☐ **No** 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death 1☐ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)* 1☑ **Certifying Physicien:** To the best of my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner ss stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, and due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: Brian Yeo, MD FACC

29c. License number: D15152

29d. Date signed *(Month, Day, Year)*: 12/18/97

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print): BRIAN YEO 801 South Union Avenue HAVRE De GRACE, MARYLAND 21078

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 23 1997

32. Registrar's Signature: Judith Sheridan-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

CULLUM, GEORGE LEWIS Yo 2013 12/18/97

20+1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41106

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Leamer Bennington Cooper

2. Date of Death Month Day Year: December 20, 1997

3. Time of Death: 7:50 AM

4a. Facility Name (If not institution, give street and number): 3629 Aldino Road

4b. City, Town, or Location of Death: Aberdeen

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-12-5352

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 9, 1904

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Aberdeen

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3629 Aldino Road

10f. Zip Code: 21001

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress

16b. Kind of Business/Industry: Clothing Manufacturing

17. Father's Name (First, Middle, Last): William Cable Pyle

18. Mother's Name (First, Middle, Maiden Surname): Octavia (u/k) Bennington

19a. Informant's Name/Relationship (Type, Print): Walter E. Ivins/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3631 Aldino RD, Aberdeen, Maryland 21001

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Wesleyan Chapel Cemetery | Date: 12-23-97

20c. Location - City or Town, State: Havre de Grace, Maryland

21. Signature of Funeral Service Licensee: Howard K. McComas

22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cerebro vascular accident — 1 WK.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

old age - Congestive Heart failure. Chr. Renal failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Kammdin Mirfam MD

29c. License number: D32C09

29d. Date signed (Month, Day, Year): 12-24-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kammdin Mirfam MD 703 Revolution St - Havre De Grace MD 21078

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997

32. Registrar's Signature: Jean Christian-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41197

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maxine K. Geiger Cantler

2. Date of Death (Month, Day, Year): Dec. 24 1997

3. Time of Death: 1730 PM

4a. Facility Name (If not institution, give street and number): Med Pointe

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 295-03-7763

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 9 1915

9. Birthplace (State or Foreign Country): Cleveland, Ohio

Usual Residence of Decedent

10a. State: DE

10b. County: New Castle

10c. City, Town or Location: Newark

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 178 S. Oxford Drive - Glasgow

10f. Zip Code: 19702

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Louis Geiger

18. Mother's Name (First, Middle, Maiden Surname): Adeline Hart

19a. Informant's Name/Relationship (Type, Print): Karen S. Celli - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1279 Town Point Rd., Chesapeake City, MD 21915

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Silverbrook Crematory

Date: 12/29/97

20c. Location - City or Town, State: Wilmington, DE

21. Signature of Funeral Service Licensee: ▶ Frank C. Mayer, Jr.

22. Name and Address of Facility: Spicer-Mullikin Funeral Homes, Inc. 1000 N. DuPont Pkwy, New Castle, DE 19720

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Pneumonia — 1 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Congestive Heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Sachdev

29c. License number: D23322

29d. Date signed (Month, Day, Year): 12/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. S SACHDEV MD. 118 North St Suite 303, Elkton MD 21921.

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41108

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mabel Moor Calloway

2. Deta of Deeth Month Day Yeer: December 31, 1997

3. Time of Death: 21:27

4e. Facility Nama *(If not institution, giva street and number)*: Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Deeth: Anne Arundel

Funeral Director

5. Social Security Number: 222-07-5920

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 76 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Dey, Yeer)*: 1-29-1921

9. Birthplace *(Stete or Foreign Country)*: Delaware

Usual Residence of Decadant

10a. Steta: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Streat end Number: 43 West McKinsey Rd.

10f. Zip Code: 21146

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Was Dacedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Give Yaar or Dates:

13. Was Dacedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* white

15. Decadent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Postal Worker

16b. Kind of Business/Industry: US Post Office

17. Fether's Neme *(First, Middle, Last)*: William Pearson

18. Mothar's Name *(First, Middle, Maiden Surname)*: No Record

19e. Informent's Name/Reletionship *(Type, Print)*: Albert Moor

19b. Meiling Addrass *(Street end Number or Rural Route Numbar, City or Town, Steta, Zip Coda)*: 115 Sleepy Point Way, Suffolk, Va. 23435

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Othar *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Old Drawyers Cem.

Deta: 1-4-98

20c. Location - City or Town, Stete: Odessa, Delaware

21. Signetura of Funeral Service Licensee

22. Name end Address of Facility: DANIELS & HUTCHISON FUNERAL HOME 212 N. Broad St., Middletown, DE. 19709

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "naturel", or items 23e or 28e-f show eny injury or other treumetic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or haart teilura. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediate Ceuse (Finel disease or condition resulting in death)

a. Ruptured Aortic Aneurism — 1 day

Dua to (or as a consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceusa (Diseese or injury thet initieted avants resulting in daath) Lest

b. HTN

Dua to (or es e consequenca of):

c.

Due to (or es e consequence of):

d.

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Wes casa referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residance 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding Investigetion 6☐ Could not be detarmined

28a. Date of Injury *(Month, Day Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, daath occurred et the time, data and piece, end dua to tha causa(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, daath occurred et tha time, data and place, end dua to tha causa(s) end manner steted.

29b. Signeture and title of certifier: Lisa Murray MD

29c. Licanse number: D38526

29d. Date signed *(Month, Day, Yeer)*: 1/1/98

30. Neme and eddress of person who completed causa of daath (Item 23e) (Type, Print): LISA MURRAY, MD 600 Ridgley Ave S120 Annapolis MD 21401

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

15

State Registrar

31. Dete filed *(Month, Day, Yeer)*: JAN 05 1998

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41109

Certificate of Death

Reg. No.

COX, MONA

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mona Weber Cox

2. Date of Death Month Day Yaer: DECEMBER 31 1997

3. Time of Death: 7:23AM

4a. Facility Name *(If not institution, give street end number)*: NORTH ARUNDEL HOSPITAL

4b. City, Town or Location of Death: GLEN BURNIE

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 214-07-7510

6. Sex: 1☐ M XX F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct 22,1907

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Glen Burnie

10d. Inside City Limits: XX Yes 2☐ No

10e. Street end Number: 131 Steeplechase Circle

10f. Zip Code: 21061

10g. Citizen of What Country?: US

11. Marital Stetus: 1☐ Naver Married 2☐ Married 3 XX Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yas XX No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.): 1☐ Yes XX No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Harry Cook

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Pearl Parks

19a. Informant's Name/Relationship *(Type, Print)*: Linda W. Jackson Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 131 Steeplechase Circle Glen Burnie, MD 21061

20e. Method of Disposition: 1 XX Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or othar place)*: East New Market Cemetery

Dete: 1/3/98

20c. Location - City or Town, Stata: East New Market, MD

21. Signature of Funeral Servica Licensee: ▶ Kenneth R Thomas Jr.

22. Name and Address of Feciliity: Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613

Physician /Medical Examiner

23a. Part1. Enter the diseesa, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only ona ceuse on each line.

Approximete Interval Between Onset end Death

Immediate Causa (Final disease or condition resulting in death): e. ASPIRATION PNEUMONIA — 4DAYS

Due to (or es a consequence of): INTESTINAL OBSTRUCTION — 1 WEEK

Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in daeth) Last

b. Due to (or as e consequence of):

c. Dua to (or es e consequence of):

d.

Part II. **Othar significant conditiona** contributing to death but not resulting in the underlying cause given In Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings aveileble prior to complation of cause of death? 1☐ Yes 2☑ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 8☐ Other *(Specify)*

27. Manner of Deeth: 1☑ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of injury *(Month, Dey Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piace of Injury - At home, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the ceuse(s) and menner as stated. 2☐ **Medical Examinar:** On the basis of axemination and/or Investigetion, in my opinion, deeth occurred et the time, date end placa, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ HOUSE STAFF MEDICINE

29c. License number: BC 5592195

29d. Dete signed *(Month, Dey, Year)*: DECEMBER 31, 1997

30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print): BINU CHACKO NORTH ARUNDEL HOSPITAL 301 HOSPITAL DRIVE GLENBURNIE, MD 21061

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 5 1998

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rav 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental Hygiena. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41110

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ELYNOR L. COATES

2. Date of Death Month Day Year: DEC. 27 1997

3. Time of Death: 1950

4a. Facility Name *(If not institution, give street and number)*: ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 577-68-5325

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)* Yrs.: 51

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUNE 3 1946

9. Birthplace *(State or Foreign Country)*: D.C.

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ANNAPOLIS

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1914 E. COPELAND STREET

10f. Zip Code: 21401

10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12th

College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: TEACHER

16b. Kind of Business/Industry: BOOK OF LIFE ACADEMY

17. Father's Name *(First, Middle, Last)*: RALPH DeVILLE

18. Mother's Name *(First, Middle, Maiden Surname)*: MARY L. WASHINGTON

19a. Informant's Name/Relationship *(Type, Print)*: ELYNOR M. WATKINS (DAUGHTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10 A SANDSTONE COURT ANNAPOLIS, MD. 21403

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: LAKEMONT MEM. GARDENS

Date: 12/31/97

20c. Location - City or Town, State: DAVIDSONVILLE, MD.

21. Signature of Funeral Service Licensee: Harry D. Reese

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. METASTATIC OVARIAN CA — 4 MOS.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: HTN

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: NA

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D50741

29d. Date signed *(Month, Day, Year)*: SUN 28 DEC 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ERICA Salata 9139 OLD SOLOMON'S ISL. RD ANNAPOLIS MD

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41111

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Eugene Arthur Dailey

2. Date of Death Month Day Year: December 30 1997

3. Time of Death: 3:45 PM

4a. Facility Name (If not institution, give street and number): St. Mary's Hospital

4b. City, Town, or Location of Death: Leonardtown

4c. County of Death: St. Mary's

Funeral Director

5. Social Security Number: 217-32-0142

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 14, 1935

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: St. Mary's

10c. City, Town or Location: Callaway

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 20172 Callaway Road

10f. Zip Code: 20620

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 10th Grade

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Walter Cornelius Dailey

18. Mother's Name (First, Middle, Maiden Surname): Juanita Sweetney Briscoe

19a. Informant's Name/Relationship (Type, Print): Mary C. Greenwell/Fiancee

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 58, Callaway, Maryland 20620

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Bethesda Church Cemetery

Date: 1/5/98

20c. Location - City or Town, State: Valley Lee, MD

21. Signature of Funeral Service Licensee: Michael K Gardiner

22. Name and Address of Facility: Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery DE — yrs.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

Head & Neck Carcinoma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? N/A 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James P. Jarboe MD

29c. License number: D 0649

29d. Date signed (Month, Day, Year): 12-31-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JAMES P. JARBOE M.D. PHILIP BEAN MEDICAL CTR. HOLLYWOOD, MD. 20636

State Registrar

31. Date filed (Month, Day, Year): JAN -6 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

EUGENE ARTHUR DAILEY

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41112

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edison Loy Durst
2. Date of Death Month, Day, Year: DECEMBER 24, 1997
3. Time of Death: 12:50AM
4a. Facility Name (If not institution, give street and number): Sacred Heart Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 215-05-0227
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 82 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 7, 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Steta: MD
10b. County: Garrett
10c. City, Town or Location: Accident
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10a. Street and Number: 2383 Devil's Half Acre Road
10f. Zip Coda: 21520
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Merried 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 5/45-12/45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondery (0-12): 7
College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Truck Driver
16b. Kind of Business/Industry: Trucking

17. Father's Name (First, Middle, Last): Jefferson Durst
18. Mother's Name (First, Middle, Meiden Surname): Lettie Platter

19a. Informant's Name/Relationship (Type, Print): Lula V. Durst/wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2383 Devil's Half Acre Rd., Accident, MD 21520

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from Steta 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Grantsville Cem., Date: Dec. 27, 1997
20c. Location - City or Town, State: Grantsville, MD

21. Signature of Funeral Service Licensee: D Lee Newman
22. Name and Address of Facility: Newman Funeral Homes, P.A., P.O. Box 275 179 Miller St., Grantsville, MD 21536

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one ceusa on each lina.

Approximate Interval Between Onsat and Death

Immediate Cause (Finel disaasa or condition resulting in death): e. Coronary artery disease — Approximate Interval: 2 years

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Last:

b. Due to (or es a consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause givan in Part I.: Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to complation of cause of deeth? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospitel: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Netural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury et Work? 1 ☐ Yas 2 ☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, straet, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and piece, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar steted.

29b. Signature and title of certifier:
29c. Licansa number: D33280
29d. Date signed (Month, Dey, Yeer): DECEMBER 24,1997

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Sunil Gupta, M.D. 625 Kent Ave # 101 Cumberland MD 21502

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 30 1997
32. Registrer's Signeture:

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41113

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Johnnie Daily

2. Dete of Deeth — Month: December; Dey: 9; Yeer: 1997

3. Time of Deeth: 05:51am

4a. Facility Neme *(If not institution, give street and number)*: JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 220-64-1699

6. Sex: 1☒M 2☐F

7. Aga *(In yrs. last birthday)*: 39 Yrs.

If Under 1 Yaar — Months: ; Deys:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Yeer)*: June 1 1958

9. Birthplece *(Steta or Foreign Country)*: MD

Usuel Residence of Decedent

10a. Stete: MD

10b. County: HARFORD

10c. City, Town or Locetion: HAVRE DE GRACE

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street end Number: 801 GARFIELD Rd.

10f. Zip Coda: 21078

10g. Citizen of What Country?: USA

11. Meritel Status: 1☒Navar Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 1☐Yas 2☒No *Specify:*

14. Race - Amarican Indien, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade complatad)*: Elementary/Secondary (0-12): 11; College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Giva kind of work done during most of working life. DO NOT use retired)*: AUTO DETAILER

16b. Kind of Business/Industry:

17. Fathar's Name *(First, Middle, Last)*: JOHNNIE LEE DAILY

18. Mother's Neme *(First, Middle, Meiden Surneme)*: MARY ELEANOR EDWARDS

19a. Informent's Neme/Relationship *(Type, Print)*: MARY E. DAILY - MOTHER

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 801 Garfield Road, Havre de Grace, MD. 21078

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: BERKLEY CEMETERY

Dete: Dec 16, 1997

20c. Locetion - City or Town, State: DARLINGTON, MD

21. Signature of Funeral Service Licensee ▶

22. Neme and Address of Facility: BEARD FUNERAL HOME, 552 LEWIS ST. HAVRE DE GRACE, MD. 21078

SH

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Health end Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the daeth. Do not anter the mode of dying, such es cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Final diseasa or condition resulting in deeth):
e. Aspiration Pneumonia — 1 hour

Due to (or es e consequence of):
b. Dementia — 6 months

Sequentially list conditions, if eny, leeding to immediata cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest:
c. Human Immunodeficiency Virus Infection — 12 years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yee 2☒No 3☐Probably 4☐Unknown

24a. Was en eutopsy performed? 1☒Yas 2☐No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐Yes 2☒No

25. Was cese referred to medical exeminer? 1☐Yes 2☒No

26. Plece of Deeth *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Menner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Locetion *(Street end Number or Rural Routa Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physicien**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐**Medicel Examiner**: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ Jeffrey A. Spaeder M.D.

29c. Licensa number: Res-000

29d. Dete signed *(Month, Dey, Yeer)*: December 9, 1997

30. Neme and eddress of person who completed ceusa of deeth (Item 23e) (Type, Print): Jeffrey A. Spaeder Johns Hopkins Hospital, Baltimore Maryland 21287

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

6

State Registrar

31. Deta filed *(Month, Day, Year)*: DEC 22 1997

32. Registrar's Signature ▶

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41114

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles Wilson Edelblute

2. Data of Death (Month, Day, Year): 12-24-1997

3. Time of Death: 7:30AM

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 216-07-4440

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 4-5-1914

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 55 Sunset Drive

10f. Zip Code: 21146

10g. Citizen of What Country? USA

To Be Completed by Funeral Director

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4or 5+): 1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist

16b. Kind of Business/Industry: Westinghouse

17. Father's Name (First, Middle, Last): Edward Edelblute

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Hoffman

19a. Informant's Name/Relationship (Type, Print): Thelma Edelblute/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 55 Sunset Drive, Severna Pk. MD 21146

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory

Date: 12-26-97

20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: 495 Ritchie Hwy. Barranco and Sons Severna Pk, MD 21146

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary Arrest — 5 minutes

Due to (or as a consequence of):

b. Pneumonia — 6 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Sepsis — 3 days

Due to (or as a consequence of):

d. Cerebrovascular disease — 10 years

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Acute Renal Failure

Chronic Renal failure

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D32654

29d. Date signed (Month, Day, Year): December 24, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): John Serlemitsos 1509 Ritchie Highway, Arnold, MD 21012

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997

32. Registrar's Signature: Sylvia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41115

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HENRY ALEXANDER ERNST
2. Date of Death (Month, Day, Year): DECEMBER 25, 1997
3. Time of Death: 3:15 am
4a. Facility Name (If not institution, give street and number): 500 SECOND AVENUE S.W.
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 213-05-6220
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 83 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JUNE 14, 1914
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. Stete: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 500 SECOND AVENUE S.W.
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.A

11. Maritei Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943-45
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuben, Mexicen, Puerto Ricen, etc.): 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 | College (1-4or 5+): N/A
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retirad): SUPERVISOR
16b. Kind of Business/Industry: A & P

17. Father's Name (First, Middle, Last): JOSEPH LEONARD ERNST, SR.
18. Mother's Name (First, Middle, Maiden Surneme): BRIDGET MARY GILMORE

19a. Informent's Name/Relationship (Type, Print): EDITH MADELINE ERNST (WIFE)
19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 500 SECOND AVENUE, S.W. GLEN BURNIE, MD 21061

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): HOLY CROSS CEMETERY
Date: 12-29-97
20c. Location - City or Town, State: BROOKLYN PARK, MD

21. Signeture of Funerai Service Licensee: Michael R Taff
22. Name end Address of Fecility: SINGLETON FUNERAL HOME, PA. 1 SECOND AVENUE S.W., GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on eech line. (Approximate Interval Between Onset and Death)

Immediate Ceuse (Final disease or condition resulting in deeth)
a. CARDIO - RESPIRATORY ARREST
Due to (or es e consequence of):
b. METASTATIC PROSTATE CANCER AND
Sequentially list conditions, if any, leading to Immediete cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Lest
Due to (or es a consequence of):
c. FAILURE TO THRIVE
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicei examiner? 1☐ Yes 2☒ No
26. Place of Deeth (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred et the time, dete and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: Anita Khadelwal MD
29c. License number: D005420
29d. Date signed (Month, Day, Year): 12/26/97

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): ANITA KHADELWAL MD, 30001 S. HANOVER ST. BALTIMORE MD

State Registrar

31. Dete filed (Month, Day, Year): DEC 30 1997
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41116

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSALIE PEARL FRALEY
2. Date of Death: Month Dec Day 30 Year 1997
3. Time of Death: 8:40pm
4e. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 193 16 6730
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 6/26/23
9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10e. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 11700 OLD COLUMBIA PIKE
10f. Zip Code: 20904
10g. Citizen of What Country?: U.S.A
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): WAITRESS
16b. Kind of Business/Industry: FOOD SERVICE
17. Father's Name (First, Middle, Last): WILLIAM SNYDER
18. Mother's Name (First, Middle, Maiden Surname): MABEL KINGNAM
19a. Informant's Name/Relationship (Type, Print): PHYLLIS FRALEY / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11700 OLD COLUMBIA PIKE, SILVER SPRING MD. 20904
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE CREMATORY INC. Date: 1/2/98
20c. Location - City or Town, State: BELTSVILLE MD.
21. Signature of Funeral Service Licensee: Alex Pope Jr
22. Name and Address of Facility: POPE FUNERAL HOME 11315 LOCKWOOD DR. SILVER SPRING, MD. 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARRHYTHMIA — MINUTES
Due to (or as a consequence of):
b. ACUTE MYOCARDIAL INFARCTION — ONE DAY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: T. J. Anthony MD
29c. License number: D50300
29d. Date signed (Month, Day, Year): DECEMBER 31, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THOMAS J ANTHONY, MD 11119 ROCKVILLE PIKE, ROCKVILLE, MD 20852

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998
32. Registrar's Signature: Julia Gwendolyn Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41117

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROSALINE FRYER
2. Date of Death (Month, Day, Year): DECEMBER 24 1997
3. Time of Death: 1655 P
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 212-08-2208
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 77 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 06-12-20
9. Birthplace (State or Foreign Country): South America

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6305 Riggs Road #311
10f. Zip Code: 20783
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): William T. Embrack
18. Mother's Name (First, Middle, Maiden Surname): Rosaline Gladstone

19a. Informant's Name/Relationship (Type, Print): Victor Fryer/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4800 49th Avenue, Hyattsville, Maryland 20781

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Cemetery
Date: 12/30/97
20c. Location - City or Town, State: Suitland, Maryland

21. Signature of Funeral Service Licensee: ▶ Charles F Bowman
22. Name and Address of Facility: J. B. Jenkins Funeral Home, 7474 Landover Road, Landover, Maryland 20785

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CEREBROVASCULAR ACCIDENT — WEEKS

Due to (or as a consequence of):
b. METASTATIC RENAL CELL CARCINOMA — MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ D. Vikramaditya Reddy MD
29c. License number: D 43464
29d. Date signed (Month, Day, Year): DECEMBER 24 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VIKRAMADITYA. D. REDDY, 11125 ROCKVILLE PIKE, SUITE 303, ROCKVILLE, MD 20852

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(4)

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997
32. Registrar's Signature: Gabi Madison-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41118

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Emelia Ford

2. Date of Death (Month, Day, Year): December 24, 1997

3. Time of Death: 5:30 p.m.

4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 274-01-8603

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 4, 1914

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4807 67th Avenue

10f. Zip Code: 20784

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Bookkeeper

16b. Kind of Business/Industry: Bureau of Labor Statistics

17. Father's Name (First, Middle, Last): John T. Walther

18. Mother's Name (First, Middle, Maiden Surname): Emelia Wannemacher

19a. Informant's Name/Relationship (Type, Print): Russell Ford - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4807 67th Avenue, Hyattsville, Maryland 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): National Memorial Park Cemetery

Date: 12/29/97

20c. Location - City or Town, State: Falls Church, Virginia

21. Signature of Funeral Service Licensee: Dorothy Jean Duty

22. Name and Address of Facility: Francis Gasch's Sons Funeal Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR ASYSTOLE — 15 min

Due to (or as a consequence of):

b. ARTERIOSCLEROTIC CARDIOVASCULAR DIS. — 8 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

MITRAL VALVE REPAIR.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier: [signature] MD

29c. License number: 11048 99

29d. Date signed (Month, Day, Year): 12/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 4203 QUEENSBURY ROAD, HYATTSVILLE, MD. 20781

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997

32. Registrar's Signature: Julia Marlene Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

18

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41119

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen F. Foster

2. Date of Death Month Day Year: December 27, 1997

3. Time of Death: 6:20 PM

4a. Facility Name (If not institution, give street and number): 3803 73rd. Avenue

4b. City, Town, or Location of Death: Landover Hills, MD

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 204-01-4564

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Yaer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Year): August 8, 1917

9. Birthplece (State or Foreign Country): Pennsylvania

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Landover Hills

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 3803 73rd. Avenue

10f. Zip Coda: 20786

10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U,S. Armed Forces? 1☐ Yes 2☒ No If Yas, Giva Yeer or Detas:

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 12

College (1-4or 5+): 0

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Sales Assistant

16b. Kind of Business/Industry: Sears

17. Fethar's Name (First, Middle, Last): Michael McAuliffe

18. Mothar's Neme (First, Middle, Meidan Surnama): Amelia Huffman

19e. Informent's Neme/Reletionship (Type, Print): Michael Foster (Son)

19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 6423 Inlet Street New Carrollton, Maryland 20784

20e. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Name of cemetery, crametory or othar placa): Mount Olivet Cemetery

Date: 12/31/97

20c. Location - City or Town, Steta: Washington, D.C.

21. Signeture of Funerel Service Licensee: Richard Rent

22. Nama end Address of Facility: Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706

Physician /Medical Examiner

23e. Part I. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cerdiec or raspiretory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in deeth)

e. MYELODYSPLASIA — 11/2 Years

Due to (or es a consequence of):

Sequentieily list conditions, if eny, leeding to immadiata cause. Enter Underlying Ceuse (Diseese or injury thet initieted avents rasulting in deeth) Last

b.

Due to (or es e consequence of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☒ No

25. Wes case referred to medicel exeminer? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, streat, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es steted. 2☐ Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and piece, and due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: Richard Rough MD

29c. License number: D08754

29d. Dete signed (Month, Day, Year): December 29, 1997

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. Ben Singer 7525 Greenway Center Drive Greenbelt, Maryland 20770

State Registrar

31. Dete filed (Month, Day, Year): DEC 29 1997

32. Registrar's Signeture: Judy Thurston Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41120

Reg. No.

FOWLER PEARL

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
PEARL	FOWLER	December 22, 1997	6:40PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
NORTH ARUNDEL HOSPITAL	GLEN Burnie	A.A. COUNTY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
129-01-0287	1☐ M 2☒ F	76 Yrs.			MAY 27, 1921	NEW YORK

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	ANNE ARUNDEL	GLEN BURNIE	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
244 MACKINTOSH DRIVE	21061	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943-1945	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	N/A	HOMEMAKER	OWN HOME

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ISADOR HALPERN	GUFFIE WINTER

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
GEORGE DEWITT FOWLER (HUSBAND)	244 MACKINTOSH DRIVE, GLEN BURNIE, MD. 21061

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	ARLINGTON NATIONAL CEMETERY	1/2/98	FORT MYER, VIRGINIA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Michael C. Taffner	SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Left Ventricular failure	minutes
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Acute Myocardial Infarction	minutes
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Max C Frank MD	D01824	12/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAX C FRANK MD 7070 Ritchie Hwy - Glen Burnie MD 2061

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 30 1997	Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 4121

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louis Goetzke

2. Date of Death: Month December, Day 23, Year 1997

3. Time of Death: 2230 PM

4a. Facility Name (If not institution, give street and number): Northwest Hospital Center

4b. City, Town, or Location of Death: Randallstown

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 212 03 6747

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): January 28, 1905

9. Birthplace (State or Foreign Country): Maryland U.S.A

Usuel Residence of Decedent

10a. State: Md.

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7200 Third Ave.

10f. Zip Code: 21784

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- if Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Staff Assistant Foreman

16b. Kind of Business/Industry: C.& P. Telephone

17. Fether's Neme (First, Middle, Last): Louis Ferdinand Goetzke

18. Mother's Neme (First, Middle, Maiden Surneme): Caroline Bryant

19e. Informent's Neme/Relationship (Type, Print): Carol Cass (daughter)

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1724 Linden Ave. Baltimore, Md. 21217

20e. Method of Disposition: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Carroll Cremation Service

Date: 12/24/97

20c. Location - City or Town, Stete: Hampstead, Md.

21. Signature of Funeral Service Licensee: ▶ Harry W. Haight

22. Name end Address of Fecility: Haight Funeral Home P.O.Box 195 Sykesville, Md. 21784

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert failure. List only one ceuse on each line.

Approximete Interval Between Onset and Deeth

Immediate Ceuse (Final diseese or condition resulting in deeth)

a. Sepsis — days

Due to (or es e consequence of):

b. Acute bronchitis — days

Sequentially list conditions, if any, leeding to Immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initiated events resulting in deeth) Lest

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

Hyperosmolar coma

Myocardial infarction 1961

Sick sinus syndrome Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings evelleble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of Injury

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☑ **Certifying Physicten:** To the best of my knowledge, death occurred et the time, dete end place, end due to the cause(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier: ▶ D Roggen MD

29c. License number: D 35844

29d. Date signed (Month, Dey, Year): December 23, 1997

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): D Roggen 5401 Old Court Road Randallstown MD 21133

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 29 1997

32. Registrar's Signeture: John Thurlow Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41122

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James H Gupton

2. Date of Death: Month December, Day 25, Year 1997

3. Time of Death: 6:26 PM

4a. Facility Name (If not institution, give street and number): MARINER HEALTH CENTER

4b. City, Town, or Location of Death: CLINTON MD

4c. County of Death: P.G. COUNTY

Funeral Director

5. Social Security Number: 242-50-5068

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): JUNE 5,1938

9. Birthplace (State or Foreign Country): NORTH CAROLINA

Usual Residence of Decedent

10a. State: MD

10b. County: P,G, COUNTY

10c. City, Town or Location: UPPER MARLBORO

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 9118 D'ARCY RD

10f. Zip Code: 20772

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TRUCK DRIVER

16b. Kind of Business/Industry: DEPT OF NAVY

17. Father's Name (First, Middle, Last): JAMES HENRY GUPTON

18. Mother's Name (First, Middle, Maiden Surname): REDDIE HARRIS

19a. Informent's Name/Relationship (Type, Print): MARY DELORES GUPTON/WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9118 D'ARCY RD UPPER MARLBORO MD 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): MARYLAND VETERANS CEMETERY

Date: 12-31-97

20c. Location - City or Town, State: CHELTENHAM MD

21. Signature of Funeral Service Licensee: Alex S. Pope M1859

22. Name and Address of Facility: ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE FORESTVILLE MD 20747

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia — Two weeks.

Due to (or as a consequence of):

b. Cerebrovascular accident

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Dementia

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, dete and piece, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Wafer C ____ M.D.

29c. License number: D50607

29d. Date signed (Month, Day, Year): December 27-1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Wafer Gamil 720 Maiden Choice lane Catonsville MD.

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997

32. Registrar's Signature: Judy Davidson Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41123

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN VINCENT GRABENSTEIN
2. Date of Death (Month, Dey, Year): December 29, 1997
3. Time of Death: 9:25 P.M.
4a. Facility Name (If not institution, give street and number): 4396 Moleton Drive
4b. City, Town, or Location of Death: Mt. Airy
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 215-20-5951
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec 16, 1924
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 543 Fairview Avenue
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Dates: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retired Employee
16b. Kind of Business/Industry: PPG Industries

17. Father's Name (First, Middle, Last): Joseph A. Grabenstein
18. Mother's Name (First, Middle, Maiden Surneme): Anna (Elliott)

19a. Informant's Name/Relationship (Type, Print): Therese Monahan--daughter
19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 4396 Moleton Drive; Mt. Airy, MD 21771

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SS Peter Paul Cemetery
Date: 01/03
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: Nicholas L Scarpelli
22. Name end Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line. (Approximate Interval Between Onset end Deeth)

Immediate Cause (Final disease or condition resulting in death): a. Cardiomyopathy (ischemic)

Due to (or es a consequenca of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Hypertension

Due to (or as e consequence of):

c. Hyperlipidemic

Due to (or as e consequence of):

d. Diabetes

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Wes cese referred to medicel exeminer? 1 [ ] Yes 2 [X] No

26. Plece of Death (Check only one): Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and menner stated.

29b. Signeture and title of certifier: MD
29c. License number: D47536
29d. Date signed (Month, Day, Year): January 30, 1997

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): Dr. William Johnson, M.D. 187 Thomas Johnson Drive Frederick, Maryland 21702

State Registrar

31. Dete filed (Month, Day, Year): JAN 02 1998
32. Registrar's Signature: John [illegible] Rudell

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit

6 mss

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41124

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LOUISE (NMN) GAUS

2. Date of Death: Month 12 Day 29 Year 1997

3. Time of Death: 805

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 146-24-2376

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): Sept. 27, 1905

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 502 Knightswood Court

10f. Zip Code: 21015

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Maurice (u/k) Neel

18. Mother's Name (First, Middle, Maiden Surname): Germaine (u/k) Darier

19a. Informant's Name/Relationship (Type, Print): John C. Jahnke - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 502 Knightswood Ct., Bel Air, MD 21015

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hilltop Service Corp.

Date: 12-29-97

20c. Location - City or Town, State: Towson, Maryland

21. Signature of Funeral Service Licensee: Howard K. McComas III

22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. progressive dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David S. Dunn

29c. License number: D32279

29d. Date signed (Month, Day, Year): December 29, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DAVID S. DUNN 615 W. MacPhail

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41125

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): ANNA Virginia GARRATT
2. Date of Deeth: Month December Dey 21 Yeer 1997
3. Time of Death: 3:35 PM
4e. Fecility Neme (If not institution, give street and number): Charlestown Care Center
4b. City, Town, or Location of Deeth: Catonsville
4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 216-48-7557
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Yeer): Oct 20, 1912
9. Birthplece (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Baltimore
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☐ Yes 2☒ No
10a. Street end Number: 715 Maiden Choice Lane, Apt. 207
10f. Zip Code: 21228
10g. Citizen of Whet Country?: USA
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indien, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12); College (1-4or 5+): 4
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Baltimore City Public School System
17. Fether's Neme (First, Middle, Last): Frederick W. Walther
18. Mother's Name (First, Middle, Maiden Sumame): Grace Wolf
19e. Informent's Name/Reletionship (Type, Print): Donald Garratt / Grandson
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12267 Woodspurge Court, Ellicott City, MD 21042
20e. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery
Dete: Dec 23 1997
20c. Location - City or Town, Stete: Baltimore, MD
21. Signeture of Funerel Service Licensee: [signature]
22. Neme end Address of Fecility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

Physician /Medical Examiner

23e. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line. (Approximate Interval Between Onset and Deeth)

Immediate Cause (Finel diseese or condition resulting in death): a. CHOLANGIOCARCINOMA — Approximate Interval: MONTHS

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.: CHRONIC HEMOLYTIC ANEMIA; SICK SINUS SYNDROME

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings evelleble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, fectory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and menner as steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: [signature]
29c. License number: D 26473
29d. Dete signed (Month, Day, Yeer): December 21, 1997

30. Neme end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print): BERNARD F KOLOSKY, MD, 711 MAIDEN CHOICE LANE, 21229

State Registrar

31. Dete filed (Month, Day, Yeer): DEC 23 1997
32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Name: _____

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41126

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mattie L. Gray

2. Date of Death (Month, Day, Year): December 17, 1997

3. Time of Death: 11:30 AM

4a. Facility Name (If not institution, give street and number): Larkin Chase Nursing Home

4b. City, Town, or Location of Death: Bowie

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 161-22-9935

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): September 24, 1923

9. Birthplace (State or Foreign Country): Memphis, Tennessee

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's County

10c. City, Town or Location: Lanham

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 9906 Stall Avenue

10f. Zip Code: 20706

10g. Citizen of What Country? United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Custodian

16b. Kind of Business/Industry: Public Schools

17. Father's Name (First, Middle, Last): Eddie Lee Walker

18. Mother's Name (First, Middle, Maiden Surname): Mary Jane Cook

19a. Informant's Name/Relationship (Type, Print): Doreen Davis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9906 Stall Avenue, Lanham, Maryland 20706

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Roselawn Memorial Gardens

Date: December 22,1997

20c. Location - City or Town, State: Vernon Township, Pennsylvania

21. Signature of Funeral Service Licensee #M00690: Howard A Causan

22. Name and Address of Facility: Byham, Miller, Mizner Funeral Home, 404 Chestnut Street, Meadville, PA 16335

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis — Approximate Interval: 1 Day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Diabetes Mellitus

Malnutrition

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dipdeo Singh MD

29c. License number: D 45660

29d. Date signed (Month, Day, Year): December 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 3060, Mitchellville Rd, Bowie MD 20716

State Registrar

31. Date filed (Month, Day, Year): DEC 23 1997

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41127

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH P. GRADY

2. Date of Death: Month December Day 30 Year 1997

3. Time of Death: 6:22 am

4a. Facility Name (If not institution, give street and number): Genesis Eldercare-Spa Creek

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 547-46-7605

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 19, 1919

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7006 Channel Village Ct. #201

10f. Zip Code: 21403

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Registered Nurse

16b. Kind of Business/Industry: Nursing

17. Father's Name (First, Middle, Last): George H. Plum

18. Mother's Name (First, Middle, Maiden Surname): Verg C. Cooke

19a. Informant's Name/Relationship (Type, Print): Jane Grady Piche (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 228 Lookout Lane Annapolis, Md. 21401

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Crematory | Date: 12-31-97

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Maryland 21401

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cardiopulmonary Arrest — 5 minutes

Due to (or as a consequence of):
b. Ovarian Cancer

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last
Due to (or as a consequence of):
c. Peritoneal Carcinomatosis

Due to (or as a consequence of):
d. Malnutrition

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
malignant Ascites
Neoplasia related weakness

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA. Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D32654

29d. Date signed (Month, Day, Year): December 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John C. Serlemitsos 1509 Ritchie Highway, Arnold, MD 21012

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997

32. Registrar's Signature: [signature] Judith Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41128

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Claude Edward Haines III

2. Date of Death Month: Dec. Day: 27 Year: 1997

3. Time of Death: 2141 PM

4a. Facility Name *(If not institution, give street and number)*: Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 214-66-0345

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 42 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 10/11/55

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Union Bridge

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 999 Trevanion Road

10f. Zip Code: 21791

10g. Citizen of Whef Country?: United States

11. Marital Stetus: 1☐ Never Married 2☐ Merried 3☐ Widowed 4☒ Divorced

12. Wes Decedenf Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedenf of Hispanic Origin? (Specify Yes or No- ff Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indian, Black, White, efc. *Specify:* White

15. Decadent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 10th grade; Collega (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT usa retired)*: Carpenter

16b. Kind of Business/Industry: Self-employed

17. Fethar's Nema *(First, Middia, Last)*: Claude Edward Haines, Jr.

18. Mother's Neme *(First, Middle, Meiden Surnema)*: Lois L. Lookingbill

19a. Informent's Name/Relationship *(Type, Print)*: Lois L. Classing mother

19b. Mailing Address *(Street end Number or Rural Routa Number, City or Town, Steta, Zip Code)*: 999 Trevanion Road Union Bridge, MD 21791

20a. Method of Dispositon: 1☐ Burial 2☒ Cremetion 3☐ Removal from Stata 4☐ Donetion 5☐ Othar *(Specify)*

20b. Piece of Disposition *(Nema of cemetery, cremetory or other place)*: Carroll Cremation, Inc.

Dete: Dec. 29

20c. Location - City or Town, State: Hampstead, Maryland

21. Signature of Funaral Service Licensee: James B Covey

22. Name and Address of Facility: Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part1. Enter tha diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrast, shock, or haart failure. List only one ceuse on each line.

Approximeta Intervel Batween Onset end Deeth

Immediate Cause (Finel disaase or condition resulting in death) e. acute inferolatual MI — 1 hr

Dua to (or es e consequance of):

Sequentielly list conditions, if any, leeding to Immediete cause. Enter Underlying Ceusa (Diseese or Injury thet initieted events resulting in deeth) Last

b. Due to (or es e consequence of):

c. Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. diabetes mellitus, pneumonia & Cardiomyopathy

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Wes casa referred to medical examiner? 1☐ Yes 2☑ No

26. Piece of Deeth *(Chack only ona)*: Hospital: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be datarmined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At homa, farm, straet, factory, office building, afc. *(Specify)*

28f. Location *(Street end Number or Rural Routa Number, City or Town, Steta)*

29a. Certifiar *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledga, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner**: On the basis of exeminetion and/or invastigation, in my opinion, deeth occurred et the time, dete end pleca, and due fo the ceuse(s) end menner steted.

29b. Signeture end titla of certifier: D Kalaria

29c. License number: D23015

29d. Date signed *(Month, Dey, Year)*: 12/27/97

30. Neme end address of person who complated cause of deeth (Item 23e) (Type, Print): D. S. KALARIA MD 217 Washington Heights, Westminster Md 21157

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 31 1997

32. Registrer's Signeture: Julie Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41129

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Joseph Horvath

2. Date of Death: Month December Day 29 Year 1997

3. Time of Death: 3:40AM

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 040-54-8515

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 43 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 24, 1954

9. Birthplace (State or Foreign Country): Connecticut

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10931 Liberty Rd.

10f. Zip Code: 21701

10g. Citizen of What Country? U.S.A.

11. Maritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Reca - American Indien, Bieck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12

College (1-4or 5+): 5+

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): research chemist

16b. Kind of Business/Industry: chemical metrology

17. Father's Neme (First, Middle, Last): John M. Horvath

18. Mother's Neme (First, Middle, Meiden Surneme): Mary B. Lujick

19e. Informent's Name/Reletionship (Type, Pnnt): Patricia A. Horvath/ wife

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 10931 Liberty Rd. Frederick, MD 21701

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Mountain Grove Cemetery

Dete: 1/3/98

20c. Location - City or Town, Stete: Bridgeport, Conn.

21. Signature of Funerel Service Licensee: Patricia O. Hartzler

22. Name end Address of Facility: Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximate Intervel Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in death)

e. disseminated cutaneous lymphoma — 4 years

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

testicular cancer

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings evailebie prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one)

Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☐ Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and piece, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: MD

29c. License number: D 21531

29d. Dete signed (Month, Day, Year): Dec. 29, 1997

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): A. Peter Pushkas, Suburban Hospital, Bethesda, MD 20814

State Registrar

31. Dete filed (Month, Day, Year): DEC 30 1997

32. Registrer's Signeture: Julie Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires thet the death certificete be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760, 301 383 3940

Dr. A. Peter Pushkas John Horvath Dec 29 - 1997 3:40 Am

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41130

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): VERNON HARVEY HUDSON

2. Dete of Deeth — Month: DECEMBER Dey: 28, Yeer: 1997

3. Time of Deeth: 2:05a.m.

4a. Facility Neme (If not institution, give street end number): 3875 MARVIN DRIVE

4b. City, Town, or Location of Deeth: INDIAN HEAD

4c. County of Deeth: CHARLES

Funeral Director

5. Social Security Number: 223-12-9044

6. Sex: 1☐ M 2☐ F — X

7. Age (In yrs. lest birthdey): 81 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): NOV. 15, 1916

9. Birthplece (State or Foreign Country): VIRGINIA

Usuel Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: MARBURY

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 5290 HIGHFIELD PLACE

10f. Zip Code: 20658

10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No — If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 11; College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): MECHANIC

16b. Kind of Business/Industry: REFRIGERATION / AIR CONDITION

17. Fether's Neme (First, Middle, Last): LONZA HUDSON

18. Mother's Name (First, Middle, Meiden Surneme): VIRGINIA WELLS

19e. Informent's Name/Relationship (Type, Print): MABEL P. HUDSON / WIFE

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 5290 HIGHFIELD PLACE MARBURY, MARYLAND 20658

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): TRINITY MEMORIAL GARDENS — Dete: 12-31-97

20c. Location - City or Town, Stete: WALDORF, MARYLAND

21. Signeture of Funerel Service Licensee: Shannon W. Ramirez SHANNON W. RAMIREZ M00798

22. Neme end Address of Fecility: THE HUNTT FUNERAL HOME, INC.- P.O. BOX 156 3035 OLD WASHINGTON ROAD WALDORF, MD. 20604

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximete Intervel Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth): a. ALZHEIMER's — 7y

Due to (or es e consequence of):

Sequentielly list conditions, if any, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest:

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only one): Hospital: 1☐ inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer):

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and menner es stated. 2☐ **Medical Exeminer:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: Krishan M. Mathur

29c. License number: D28352

29d. Dete signed (Month, Dey, Yeer): DECEMBER 29,1997

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): KRISHAN MATHUR, M.D., P.O. BOX 2729, LA PLATA, MD 20646

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 06 1998

32. Registrer's Signeture: Julie Henderson Rardell

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41131

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HARRY TAYLOR HOUCHENS

2. Date of Death (Month, Day, Year): DECEMBER 21, 1997

3. Time of Death: 10:45 AM

4a. Facility Name *(If not institution, give street and number)*: 12420 FLETCHERTOWN ROAD

4b. City, Town, or Location of Death: BOWIE

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 214-05-2734

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JUNE 12, 1912

9. Birthplace *(State or Foreign Country)*: VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: PRINCE GEORGE'S

10c. City, Town or Location: BOWIE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 12420 FLETCHERTOWN ROAD

10f. Zip Code: 20720

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MECHANIC

16b. Kind of Business/Industry: AUTO REPAIR

17. Father's Name *(First, Middle, Last)*: THOMAS EDLOW HOUCHENS

18. Mother's Name *(First, Middle, Maiden Surname)*: VASHTI HARLOW

19a. Informant's Name/Relationship *(Type, Print)*: ANNA M. BUTTON, DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1510 BALL ROAD, PORT REPUBLIC, MARYLAND 20676

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: FORT LINCOLN CEMETERY | Date: 12/24/97

20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: Lisa L. Alverson

22. Name and Address of Facility: FORT LINCOLN FUNERAL HOME, 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE — 2 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. HYPERTENSIVE CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

AORTIC STENOSIS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M Schwartz MD

29c. License number: D22117

29d. Date signed *(Month, Day, Year)*: DECEMBER 22, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MICHAEL SCHWARTZ, M.D., 7500 HANOVER PARKWAY, SUITE 204, GREENBELT, MD 20770

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(10)

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997

32. Registrar's Signature: Julie Bowden Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41132

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDITH HAWKINS

2. Date of Death Month / Day / Year: December 19, 1997

3. Time of Death: 12:23 P.M.

4a. Facility Name *(If not institution, give street and number)*: 5607 Regency Park Court, #7

4b. City, Town, or Location of Death: Suitland

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-46-5826

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 17, 1936

9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Suitland

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5607 Regency Park Court, #7

10f. Zip Code: 20746

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* African American

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Meat Wrapper

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Edward Hopkins

18. Mother's Name *(First, Middle, Maiden Surname)*: Emma Brown

19a. Informant's Name/Relationship *(Type, Print)*: Karen McIntosh - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1233 Torchlight Way, Raleigh, N.C. 27603

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Maryland Veterans Cemetery

Date: 12/30/97

20c. Location - City or Town, State: Cheltenham, MD

21. Signature of Funeral Service Licensee: ▶ John T. Stewart III

22. Name and Address of Facility: STEWART FUNERAL HOME, Inc. 4001 Benning Road, N. E., Washington, D. C.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Coronary Artery Disease — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive Heart Failure; Cardiomyopathy - Pulmonary Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Sam Tellawi

29c. License number: D34274

29d. Date signed *(Month, Day, Year)*: 12-24-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sam Tellawi, M.D., 7700 Old Branch Avenue, Clinton, Maryland 20735

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997

32. Registrar's Signature: Julia Hudson Parker

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41133

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: IVA IRENE HANNEN

2. Date of Death — Month: 12 Day: 20 Year: 97

3. Time of Death: 6:10 PM

4a. Facility Name *(If not institution, give street and number)*: 43 MARTIN ROAD

4b. City, Town, or Location of Death: CONOWINGO

4c. County of Death: CECIL COUNTY

Funeral Director

5. Social Security Number: 215-36-4730

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAR. 21, 1910

9. Birthplace *(State or Foreign Country)*: KANSAS

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CECIL COUNTY

10c. City, Town or Location: CONOWINGO

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 43 MARTIN ROAD

10f. Zip Code: 21918

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: CLERK

16b. Kind of Business/Industry: BANKING INDUSTRY

17. Father's Name *(First, Middle, Last)*: NORMAN DAILEY

18. Mother's Name *(First, Middle, Maiden Surname)*: NETTIE RIMEY

19a. Informant's Name/Relationship *(Type, Print)*: JAMES N. HANNEN, SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 14700 STURTEVANT ROAD, SILVER SPRING, MD 20905

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: FORT LINCOLN CEMETERY

Date: 12/23/97

20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: Kia S Johnson

22. Name and Address of Facility: FORT LINCOLN FUNERAL HOME, 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CEREBROVASCULAR ACCIDENT — 2 WEEKS

Due to (or as a consequence of):

b. HYPERTENSION — 10 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

HYPOTHYROIDISM

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Philip W. Halstead MD

29c. License number: D50803

29d. Date signed *(Month, Day, Year)*: 12/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PHILIP W. HALSTEAD, MD 1200 BRASS MILL RD, BELCAMP, MD 21017

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997

32. Registrar's Signature: Jaja. Thurber-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 97 41134

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAE B. HINES

2. Date of Death (Month, Day, Year): December 24, 1997

3. Time of Death: 3:00 AM

4a. Facility Name (If not institution, give street and number): Memorial Hospital

4b. City, Town, or Location of Death: Cumberland

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 231-38-9536

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 16, 1913

9. Birthplace (State or Foreign Country): WV

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: WV

10b. County: Mineral

10c. City, Town or Location: Wiley Ford

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: General Delivery

10f. Zip Code: 26767

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Former Employee

16b. Kind of Business/Industry: Crystal Laundry

17. Father's Name (First, Middle, Last): Henry A. Carlile

18. Mother's Name (First, Middle, Maiden Surname): Catherine (Baker)

19a. Informant's Name/Reletionship (Type, Print): Tammy Fields--granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 104; Springfield, WV 26763

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Wesley Chapel Cemetery

Data: 12/27

20c. Location - City or Town, State: Points, WV

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CEREBROVASCULAR Accident — Three Days

Due to (or as a consequence of):

b. Coronary Artery Disease — 8 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D 36766

29d. Date signed (Month, Day, Year): December 26, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Dr. Vik Poonai 922 National Hwy LaVale, MD 21502

State Registrar

31. Date filed: DEC 31 1997

DHMH 16 Rev 6/95

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

MAE B HINES 231-38-9536

97 41135

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Darrell B. Hullett			2. DATE OF DEATH (Month, Day, Year): 12 25 1997	3. TIME OF DEATH: 4:22 PM M
4. SOCIAL SECURITY NUMBER: 513-22-9099	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Mar. 15, 1931	8. BIRTHPLACE (State or Foreign Country): Kansas
9a. FACILITY NAME (If not institution, give street and number): VA Maryland Health Care System		9b. CITY, TOWN OR LOCATION OF DEATH: Perry Point		9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Aberdeen	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 806 Paradise Road		10f. ZIP CODE: 21001	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Military	16b. KIND OF BUSINESS/INDUSTRY: U.S. Army	
17. FATHER'S NAME (First, Middle, Last): Lewis E. Hullett		18. MOTHER'S NAME (First, Middle, Maiden Surname): UNK	
19a. INFORMANT'S NAME (Type/Print): Mrs. Akiko Hullett (Spouse)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 806 Paradise Road, Aberdeen, Maryland 21001	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): R. A. Ferris & Co., Inc. DATE: 12/30	20c. LOCATION — City or Town, State: West Chester, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kenneth B. Cargo		22. NAME AND ADDRESS OF FACILITY: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):	Minutes
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF):	25 YEARS
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Oropharyngeal Carcinoma
Peripheral Vascular Disease

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☒ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D43615	29d. DATE SIGNED (Month, Day, Year): ▶ 12/29/97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lois A. Killewich, M.D. VA Maryland Health Care System, Balto., MD 21201		
31. DATE FILED (Month, Day, Year): DEC 30 1997	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMH-18 Rev 1/89

1271

(2)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41136

Physician /Medical Examiner | **Funeral Director**

1. Decedent's Name (First, Middle, Last): JAMES J. HAYNES
2. Date of Death Month / Day / Year: December 21 1997
3. Time of Death: 11:45 AM
4a. Facility Name (If not institution, give street and number): LORIEN NURSING HOME
4b. City, Town, or Location of Death: BELCAMP
4c. County of Death: HARFORD
5. Social Security Number: 717-07-4544
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MAR 28 1915
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: HARFORD
10c. City, Town or Location: EDGEWOOD
10d. Inside City Limits: 1 X Yes 2 ☐ No
10e. Street and Number: 2011 ROCKWELL
10f. Zip Code: 21040
10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): UNK
16b. Kind of Business/Industry: Chemical

17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Surname): EVA - UNK

19a. Informant's Name/Relationship (Type, Print): Maima Kenyatta
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5126 Fenbridge Ave. Baltimore, Md. 2125

20a. Method of Disposition: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Greenmount Cemetery | Date: 12/26/97
20c. Location - City or Town, State: Baltimore, Md.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Beard Funeral Home 552 Lewis St Havre De Grace, Md. 2078

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Colon Cancer — 1 year
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Malnutrition

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopay findings available prior to completion of ceuse of death? 1 ☐ Yes 2 X No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 X No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Menner of Deeth: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Phyelcian:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner es stated. 2 ☐ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D28339
29d. Date signed (Month, Day, Year): December 22 1997
30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print): Linda Mitchell (or) C. Neel Rowland MD 2011

State Registrar

31. Dete filed (Month, Day, Year): DEC 29 1997
32. Registrer's Signature: [signature] Judi Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

JAMES J. HAYNES, Jr.
Balto
2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41137

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lisa Lynn Hughes

2. Date of Death: Month 12 Day 23 Year 1997

3. Time of Death: 1920

4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-72-8858

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 25 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/02/1972

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 509 Girard St.

10f. Zip Code: 21078

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): N/A

16b. Kind of Business/Industry: N/A

17. Father's Name (First, Middle, Last): Robert Leroy Hughes

18. Mother's Name (First, Middle, Maiden Surname): Deborah Lynn Forton

19a. Informant's Name/Relationship (Type, Print): Deborah VanDyke-Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 509 Girard St. Havre de Grace, MD 21078

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Angel Hill Cemetery

Date: 12/27/97

20c. Location - City or Town, State: Havre de Grace, MD

21. Signature of Funeral Service Licensee: ▶ George M. Hampton Jr.

22. Name and Address of Facility: Mitchell-Smith Funeral Home 123 S. Washington St. Havre de Grace, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Cardiorespiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. History of H.I.V. infection

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M.D

29c. License number: D20661

29d. Date signed (Month, Day, Year): 12/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 669 Revolution St Havre de Grace MD. J.T. LEE M.D.

State Registrar

31. Date Filed (Month, Day, Year): DEC 29 1997

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

HUGHES, Lisa H 219725858 12-23-97 @ 1920 Lyf

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41138

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roy Ralph Hall

2. Date of Death (Month, Day, Year): December 20, 1997

3. Time of Death: 8:56 A.M.

4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 227-42-4516

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 63 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 19,1934

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Cheverly

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6424 Kilmer Street

10f. Zip Code: 20785

10g. Citizen of What Country? United States of America

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tree Expert

16b. Kind of Business/Industry: Forestry

17. Father's Name (First, Middle, Last): Clifford Lynn Hall

18. Mother's Name (First, Middle, Maiden Surname): Beulah Crigger

19a. Informant's Name/Relationship (Type, Print): Margaret G. Hall/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6424 Kilmer Street, Cheverly, Maryland 20785

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fairview United Methodist

Date: Cemetery December 23,1997

20c. Location - City or Town, State: Wytheville, Virginia

21. Signature of Funeral Service Licensee: #M00690 Howard A. Carson

22. Name and Address of Facility: Barnett Funeral Home 325 South Church Street, Wytheville, Virginia

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c. hypertension

Due to (or as a consequence of):

d. Diabetes mellitus

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

chronic obstructive lung disease

23b. **Did tobacco use contribute to the cause of death?** 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Don B Cameron MD

29c. License number: D 01805

29d. Date signed (Month, Day, Year): December 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Don B. Cameron, M.D. 6005 Landover Road, Cheverly, Maryland

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41139

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): HARRY HAY, JR

2. Date of Death (Month, Day, Year): DECEMBER 23, 1997

3. Time of Death: 14:20 PM

4a. Facility Name (If not institution, give street and number): HOPKINS BAYVIEW MEDICAL CTR

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 213-24-9554

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10-17-29

9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 708 PAMELA ROAD

10f. Zip Code: 21061

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [ ] No If Yes, Give Yeer or Detes: 1946-1966

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12; College (1-4or 5+): NONE

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): PURCHASING AGENT

16b. Kind of Business/Industry: COTTON INDUSTRY

17. Fether's Neme (First, Middle, Last): HARRY OLIVER HAY, SR.

18. Mother's Neme (First, Middle, Meiden Surneme): ELIZABETH LOOKABAUGH

19a. Informent's Neme/Relationship (Type, Print): PATRICIA A. HAY

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 708 PAMELA ROAD GLEN BURNIE, MARYLAND 21061

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): CHESAPEAKE CREMATORY INC.

Dete: 12-26

20c. Location - City or Town, Stete: BELTSVILLE, MARYLAND

21. Signeture of Funeral Service Licensee: [signature]

22. Name end Address of Feciility: SINGLETON FUNERAL HOME PA 1 SECOND AVE. S.W. GLEN BURNIE, MARYLAND 21061

Physician /Medical Examiner

23e. Pert1. Enter the disease or complications thet caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediete Ceuse (Finel disease or condition resulting in death) e.	PNEUMONIA	6 days
Due to (or es e consequence of):	IPF	4 YRS
Sequentielly list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest b.		
Due to (or es a consequence of): c.		
Due to (or es e consequence of): d.		

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.: MYOCARDIAL ISCHEMIA

23b. Did tobacco use contribute to the cause of deeth? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings evailable prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospitel: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and piece, and due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the besis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete and piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: [signature] GLASSMAN MD PGYI

29c. License number: 97016

29d. Date signed (Month, Dey, Yeer): DECEMBER 23, 1997

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): JP GLASSMAN, MD : BAYVIEW MED CTR, 4940 EASTERN AVE, BALTIMORE

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 30 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentel Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41140

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Andrew Hodney

2. Date of Death (Month, Day, Year): DECEMBER 29, 1997

3. Time of Death: 12:10PM

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

Funeral Director

5. Social Security Number: 544-64-9119

6. Sex: 1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday): 43 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 10/6/54

9. Birthplace (State or Foreign Country): Oregon

Usual Residence of Decedent

10a. State: M D

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1 ☐ Yes 2 ☐ No

10e. Street and Number: 531 Harbor Drive

10f. Zip Code: 21403

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: '74-'93

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4 or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Monitored Exports

16b. Kind of Business/Industry: U.S.A.F.

17. Father's Name (First, Middle, Last): Andrew Hodney

18. Mother's Name (First, Middle, Maiden Surname): Violet Dickson

19a. Informant's Name/Relationship (Type, Print): Patricia Hodney / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 531 Harbor Dr. Annapolis, MD 21403

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Hillcrest Cemetery

Date: 12/31/97

20c. Location - City or Town, State: Annapolis, MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: John M. Taylor Funeral Home 147 Duke Of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. ischemic bowel — 11 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: JMHardacre MD surgery resident

29c. License number: RES-000

29d. Date signed (Month, Day, Year): December 29, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Jeffrey Max Hardacre 5241 Downing Road Baltimore, Maryland 21212

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 97 41141

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LUCILLE LUCAS JACKSON

2. Date of Death Month Day Year: DECEMBER 13, 1997

3. Time of Death: 11:15 AM

4a. Facility Name *(If not institution, give street and number)*: WASHINGTON ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: TAKOMA PARK

4c. County of Death: MONTGOMERY COUNTY

Funeral Director

5. Social Security Number: 579-30-3858

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: APR. 4, 1927

9. Birthplace *(State or Foreign Country)*: WASHINGTON, DC

Usual Residence of Decedent

10e. State:

10b. County:

10c. City, Town or Location: WASHINGTON, D.C.

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2102 SUITLAND TERRACE, S.E., #202

10f. Zip Code: 20020

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: NOT EMPLOYED

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: BENJAMIN JACKSON

18. Mother's Name *(First, Middle, Maiden Surname)*: ANNIE LUCAS

19a. Informant's Name/Relationship *(Type, Print)*: LEONARD H. JACKSON, HUSBAND

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2102 SUITLAND TERRACE, S.E., #202, WASH., DC 20020

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: FORT LINCOLN CEMETERY

Date: 12/19/97

20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: Lisa S. Johnson

22. Name and Address of Facility: FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MD 20722

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

CR

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

BI-HEMISPHERIC STROKE WITH QUADRIPLEGIA

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul A. DeVore

29c. License number: D01852

29d. Date signed *(Month, Day, Year)*: DECEMBER 23, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): PAUL A. DeVORE, M.D., 4203 QUEENSBURY ROAD, HYATTSVILLE, MARYLAND 20781

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(2)

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997

32. Registrar's Signature: Judy Thurston Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41142

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: OLEDA VIRGINIA KETTERMAN

2. Date of Death (Month, Day, Year): DECEMBER 26 1997

3. Time of Death: 6:05 AM

4a. Facility Name *(If not institution, give street and number)*: 11105 FOREST AVE. N.E.

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 217-42-6790

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCTOBER 26 1943

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 11105 FOREST AVE N.E.

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: BRUNNERS RESTAURANT

16b. Kind of Business/Industry: DELIVERY DRIVER

17. Father's Name *(First, Middle, Last)*: ALVIN KETTERMAN

18. Mother's Name *(First, Middle, Maiden Surname)*: ELVA KETTERMAN

19a. Informant's Name/Relationship *(Type, Print)*: ELVA KETTERMAN MOTHER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11105 FOREST AVE N.E. CUMBERLAND MARYLAND 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SUNSET CEMETERY

Date: DECEMBER 29 1997

20c. Location - City or Town, State: CUMBERLAND MARYLAND

21. Signature of Funeral Service Licensee: Dale L. Merritt

22. Name and Address of Facility: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carcinoma of Lung — 1 yr.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D33280

29d. Date signed *(Month, Day, Year)*: Dec 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR SUNIL K. GUPTA 625 KENT AVE CUMBERLAND MARYLAND 21502

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

OLEDA VIRGINIA KETTERMAN

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41143

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROBERT BROOKE KNIERIEM, SR.

2. Date of Death Month Day Year: DECEMBER 26 1997

3. Time of Death: 2:45 PM

4e. Facility Name *(If not institution, give street and number)*: MEMORIAL HOSPITAL & MEDICAL CENTER

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 215-26-9595

6. Sex: X M 2 F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 23, 1926

9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Cumberland

10d. Inside City Limits: X Yes 2 No

10e. Street and Number: 13301 Winchester Road SW

10f. Zip Code: 21502

10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married X Married 3 Widowed 4 Divorced

12. Was Decedent Ever In U.S. Armed Forces? X Yes 2 No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 Yes X No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Retired

16b. Kind of Business/Industry: PPG Works #7

17. Father's Neme *(First, Middle, Last)*: John Peter Knieriem

18. Mother's Neme *(First, Middle, Maiden Sumeme)*: Lydia (Arnold)

19a. Informent's Name/Relationship *(Type, Print)*: Almeda C. Knieriem-wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13301 Winchester Road SW Cumberland MD 21502

20a. Method of Disposition: 1 Burial X Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Cumberland Crematory

Date: 12/29

20c. Location - City or Town, State: Cumberland MD

21. Signature of Funeral Service Licensee: Nicholas J. Scarpelli

22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. PROSTATE CARCINOMA — 1 YEAR

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the undertying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 Yes 2 No

25. Wes case referred to medical exeminer? 1 Yes 2 X No

28. Place of Death *(Check only one)*: Hospital: 1 X Inpetient 2 ER/Outpatient 3 DOA — Other: 4 Nursing Home 5 Residence 8 Other *(Specify)*

27. Manner of Deeth: 1 X Netural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end manner as stated. 2 **Medical Examiner:** On the basis of exemination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: V. Poonai

29c. License number: D36766

29d. Date signed *(Month, Day, Year)*: Dec 29, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): VIK POONAI M.D., 922 NATIONAL HWY., LAVALE, MD 21502

State Registrar

31. Date filed *(Month, Dey, Year)*: DEC 30 1997

32. Registrar's Signature: Gabi Shipley Kimball

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, 215-26-9595

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

ROBERT KNIERIEM 215-26-9595

Man 6

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41144

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Herbert (NMN) Kellison

2. Date of Death: Month December Day 21 Year 1997

3. Time of Death: 8:00 A.M.

4a. Facility Name (If not institution, give street and number): 504 Concord Drive

4b. City, Town, or Location of Death: Perryville

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 236-20-0289

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 86 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 25, 1911

9. Birthplace (State or Foreign Country): W. Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Cecil

10c. City, Town or Location: Perryville

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 504 Concord Drive

10f. Zip Code: 21903

10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lumberjack

16b. Kind of Business/Industry: Lumber

17. Father's Name (First, Middle, Last): James Omer Kellison

18. Mother's Name (First, Middle, Maiden Surname): Flora Minerva McGlaughlin

19a. Informant's Name/Relationship (Type, Print): Mazie Kellison - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 504 Concord Drive, Perryville, Maryland 21903

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harford Memorial Grdns. Date: 12-24-97

20c. Location - City or Town, State: Aldino, Maryland

21. Signature of Funeral Service Licensee: Howard K. McComas

22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Melanoma Face — 1 yr.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma Prostate Chr. Renal failure. Congestive Heart failure Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William MD

29c. License number: D32609.

29d. Date signed (Month, Day, Year): 12/23/97.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Kammdan William MD 703 Revolutionst Havre De Grace MD 21078

State Registrar

31. Date filed (Month, Day, Year): DEC 23 1997

32. Registrar's Signature: Gladys Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41145

Certificate of Death Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY ELIZABETH KELLY

2. Date of Death Month Day Year: December 24, 1997

3. Time of Death: 10:10 P.M.

4a. Facility Name *(If not institution, give street and number)*: North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: A.A. County

Funeral Director

5. Social Security Number: 212-42-2566

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: FEBRUARY 17, 1908

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: GLEN BURNIE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 311 CENTRAL AVENUE

10f. Zip Code: 21061

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☐ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOME MAKER

16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: EMORY ELDRIDGE MURPHY

18. Mother's Name *(First, Middle, Maiden Surname)*: AMANDA JANE McCUBBINS

19a. Interment's Name/Relationship *(Type, Print)*: ROSE GEORG (DAUGHTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8356 W. BALT. & ANNAP. BLVD SEVERN, MD 21144

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MOUNT OLIVET

Date: 12-30-97

20c. Location - City or Town, State: FREDERICK, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: SINGLETON FUNERAL HOME, PA
1 SECOND AVENUE, S.W. GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Acute Stroke — 3 hrs

Due to (or as a consequence of):
b. Massive Intracerebral Bleed — 3 hrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] DO

29c. License number: H17744

29d. Date signed *(Month, Day, Year)*: 12/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID SCHWARTZ, M.D., 300 HOSPITAL DRIVE, STE. 215, GLEN BURNIE, MD. 21061

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Kelly, Mary
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41146

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOROTHY MAY KISINGER
2. Date of Death (Month, Day, Year): DECEMBER 23, 1997
3. Time of Death: 2100
4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 380-18-3849
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): FEB. 24, 1923
9. Birthplace (State or Foreign Country): MICHIGAN

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 302 FERNGLEN AVENUE
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): NSA
16b. Kind of Business/Industry: NSA

17. Father's Name (First, Middle, Last): RAYMOND BLANCHARD
18. Mother's Name (First, Middle, Maiden Surname): CATHERINE NEESON

19a. Informant's Name/Relationship (Type, Print): STACEY LEIGH PARSON (GRAND-DAUGHTER)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 920 OVERBROOK ROAD, BALTIMORE, MARYLAND 21239

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): CHESAPEAKE CREMATORY, INC. | Date: 12/29/97
20c. Location - City or Town, State: BELTSVILLE, MD.

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: 4 years

Immediate Cause (Final disease or condition resulting in death): a. CARDIOMYOPATHY
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: PAUL YOUNG-HYMAN, M.D. [signature] Physician
29c. License number: MD 26664.
29d. Date signed (Month, Day, Year): 12/29/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 7845 OAKWOOD RD. GLEN BURNIE, MD 21061.

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41147

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ANNA LEX

2. Date of Death: Month DECEMBER Day 23, Year 1997

3. Time of Death: 08:35PM

4a. Facility Name (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 577-34-4190

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 99 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 1, 1898

9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Landover Hills

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4236 71st Avenue

10f. Zip Code: 20784

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Beautician

16b. Kind of Business/Industry: Beauty Shop

17. Father's Name (First, Middle, Last): James Robert Tweedy

18. Mother's Name (First, Middle, Maiden Surname): Sara (Unavailable)

19a. Informant's Name/Relationship (Type, Print): Anne Freitag - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4236 71st Avenue, Landover Hills, Maryland 20784

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cemetery | Date: 1/2/98

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Henry A. Freitag

22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 10 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

APPROVAL, MEDICAL EXAMINER PENDING

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

LEFT INTERTROCHANTERIC HIP FRACTURE

SUBCAPITAL RIGHT HIP FRACTURE

23b. Did Tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 12-8-97

28b. Time of Injury: 09:30PM FOUND

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: FOUND ON THE FLOOR INFRONT OF THE BATHROOM

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): NURSING HOME

28f. Location (Street and Number or Rural Route Number, City or Town, State): 2900 MERCY LANE, CHEVERLY, MARYLAND

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D04899

29d. Date signed (Month, Day, Year): 12/31/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DENNIS J. HAND 4203 QUEENSBURY ROAD, HYATTSVILLE, MD 20781

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

10

DHMH 16 Rev 6/95

97-7518-013
jhm
RAYMOND LEE
ALLEN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #12 Per F.D., 12/31/97, Carroll Co., wjl

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 97 41148

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Allen Raymond Lee	DECEMBER 27, 1997	13:40 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
6513 CARROLL HIGHLANDS ROAD	Sykesville	CARROLL

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-22-1907	1☒ M 2☐ F	70 Yrs.			Sept. 28, 1927	Minnesota

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Carroll	Sykesville	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6513 Carroll Highlands Road	21784	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates: 1944-1966	1☐ Yas 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highast grada complatad)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12th		Ret: Master Chief Ship Fitter US Navy	

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William Jennings Lee	Jessie Pearl Peters

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
Byron R. Lee Brother	11230 Daysville Road Frederick, MD 21701

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other (Specify)	Carroll Cremation, Inc.	Dec. 31	Hampstead, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
James B Covey	Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consaquance of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Inspection 1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stephen S. Radentz, MD	OCME	DECEMBER 28, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 29 1997	Julia Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41149

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FRANCES MAE LEE
2. Date of Death (Month, Day, Year): DECEMBER 24, 1997
3. Time of Death: 12:19 am
4a. Facility Name (If not institution, give street and number): 1119 Wentworth Drive
4b. City, Town, or Location of Death: Oxon Hill, MD
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 241-18-8402
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 30, 1921
9. Birthplace (State or Foreign Country): Smithfield, NC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Oxon Hill
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1119 Wentworth Drive
10f. Zip Code: 20745
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FOOD SERVICE
16b. Kind of Business/Industry: PRIVATE

17. Father's Name (First, Middle, Last): Walter Sanders
18. Mother's Name (First, Middle, Maiden Surname): Adell Mitchener

19a. Informant's Name/Relationship (Type, Print): Alice Stevenson (Daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1119 WENTWORTH DRIVE OXON HILL MD 20745

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Lincoln Memorial Cemetery | Date: 12/29/97
20c. Location - City or Town, State: Suitland, MD

21. Signature of Funeral Service Licensee: Larry L Simmons
22. Name and Address of Facility: Alexander S. Pope Funeral Home, 2617 Pennsylvania Ave SE Washington, DC 20020

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Diffuse Metastatic Disease	weeks
Due to (or as a consequence of): b.	Ovarian Carcinoma	weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Pleural Effusion

Ascites

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Barry D. Parker MD
29c. License number: 5168 D.C.
29d. Date signed (Month, Day, Year): 12/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Boisey O. Barnes, MD 2041 M.L.King Ave.,S.E. Wash.,D.C. 20020

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997
32. Registrar's Signature: Jackie Henderson-Rankin

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41150

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): IVY LUKE-TAYLOR
2. Date of Death (Month, Day, Year): DECEMBER 23, 1997
3. Time of Death: 09:13 AM
4a. Facility Name (If not institution, give street and number): 6821 WEST FOREST DRIVE # 203
4b. City, Town, or Location of Death: LANDOVER
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 228-53-9803
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 26, 1921
9. Birthplace (State or Foreign Country): Sierra Leone, W.A.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Landover
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6821 West Forest Drive, Apt. 203
10f. Zip Code: 20785
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Accounts Clerk
18b. Kind of Business/Industry: Govt.

17. Father's Name (First, Middle, Last): Christian Luke
18. Mother's Name (First, Middle, Maiden Surname): Christiana Sawyer

19a. Informant's Name/Relationship (Type, Print): Olive E. Taylor/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6821 West Forest Rd, Landover, Maryland 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
Date: 12/27/97
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: J.B. Jenkins Funeral Home, 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] DME
29c. License number: D33954
29d. Date signed (Month, Day, Year): DECEMBER 27, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): MARIO F. GOLIA JR. MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41151

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: HELEN MAXINE LONGERBEAM

2. Date of Deeth Month Day Year: DECEMBER 27,1997

3. Time of Death: 0230 AM

4a. Feciliity Neme *(If not Institution, give street end number)*: SACRED HEART HOSPITAL

4b. City, Town, or Location of Deeth: CUMBERLAND

4c. County of Deeth: ALLEGANY

Funeral Director

5. Social Security Number: 220-10-9058

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthdey)*: 79 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: JAN 11,1918

9. Birthplece *(Stete or Foreign Country)*: WEST VIRGINIA

Usual Residence of Decedent

10e. Stete: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: CRESAPTOWN

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14011 BRANT ROAD SW

10f. Zip Code: 21502

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 11 / College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE

16b. Kind of Business/Industry: OWN HOME

17. Fether's Neme *(First, Middle, Last)*: CHALLISS CAIN

18. Mother's Neme *(First, Middle, Meiden Surneme)*: CLARA BOGGS

19e. Informent's Name/Relationship *(Type, Print)*: JAMES R. LONGERBEAM, HUSBAND

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 14011 BRANT ROAD SW., CRESAPTOWN, MD 21502

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*: HILLCREST BURIAL PARK

Dete: DEC 30,1997

20c. Location - City or Town, Stete: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Douglas A. Hafer

22. Neme end Address of Feciliity: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LA VALE, MD 21502

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth)

e. ACUTE RESPIRATORY FAILURE — 15 days.

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

b. PNEUMONIA NOSOCOMIAL — 15 days

Due to (or es e consequence of):

c. ACUTE RENAL FAILURE — 25 days

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: ACUTE RECURRENT CONGESTIVE HEART FAILURE

23b. Did tobacco use contribute to the cause of deeth? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☑ No

24b. Were eutopsy findings evelleble prior to completion of cause of deeth? 1☐ Yes 2☑ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Exeminer:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: MD

29c. License number: D-23334

29d. Dete signed *(Month, Dey, Year)*: DECEMBER 27th 1997

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): D SHAH, MD; 205 JOHNSON HTS MED BLDG, CUMBERLAND, MD 21502

State Registrar

31. Dete filed *(Month, Dey, Year)*: DEC 29 1997

32. Registrar's Signature

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Heelth end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

10 mlf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41152

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: NEVA ELSIE LEE

2. Date of Death Month Dey Year: Dec. 27 1997

3. Time of Death: 7:00P.M.

4a. Facility Name *(If not institution, give street and number)*: 553 Savage River Road

4b. City, Town, or Location of Death: Swanton

4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 215-58-6989

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Oct. 11 1912

9. Birthplace *(Stete or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Garrett

10c. City, Town or Location: Swanton

10d. Inside City Limits: 1☐Yas 2☒No

10e. Street and Number: 553 Savage River Road

10f. Zip Code: 21561

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Naver Married 2☐Married 3☒Widowad 4☐Divorcad

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Spacify Yas or No- If Yes, spacify Cuban, Mexican, Puarto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest greda completed)*: Elementery/Secondery (0-12): Unknown | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Sales Represenative

16b. Kind of Business/Industry: Home Products

17. Fathar's Name *(First, Middle, Last)*: John Sweitzer

18. Mother's Name *(First, Middle, Meidan Surneme)*: Homa A. Bowser

19a. Informant's Name/Relationship *(Type, Print)*: Glen M. Lee

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 15604 Winslow St. Cumberland, Md. 21502

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: George Cemetery | Date: 12-31-97

20c. Location - City or Town, State: Swanton, Md.

21. Signature of Funeral Service Licensee: F. Wyndham

22. Name and Address of Facility: Boal Funeral Home 111 Church St. Westernport, Md.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter tha diseasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lina. | Approximate Interval Between Onsat and Death

Immediate Cause (Final diseasa or condition resulting in death): e. Respiratory failure — 1 week

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last:

b. Parkinson's disease — 10 yrs

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Homa 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. injury at Work? 1☐Yes 2☐No | 28d. Describa how injury occurred

28e. Place of injury - At home, farm, street, factory, offica building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner es stated. 2☐**Medical Examiner**: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: R J Joshi, M.D.

29c. Licansa number: WV 17089

29d. Data signed *(Month, Dey, Year)*: 12-29-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RAJENDRA JOSHI 690 S. Mineral St Keyser, WV 26726

12 mlf

State Registrar

31. Date filed *(Month, Day, Yeer)*: DEC 29 1997

32. Registrar's Signature: Gibi Sheridan Rudolph

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 41153

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CHARLES FIELDER LEWIS
2. Date of Death (Month, Day, Year): DEC 30, 1997
3. Time of Death: 12:14 a.m.
4a. Facility Name (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL
4b. City, Town, or Location of Death: CLINTON
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 212-12-4051
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 23, 1915
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 11604 Molly Berry Road
10f. Zip Code: 20772
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - Americen Indian, Bieck, White, etc. Specify: Black

15. Decedent's Educetion (Specify only highest grede completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Mail Carrier
16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Charles Lewis
18. Mother's Name (First, Middle, Meiden Surneme): Edna Lewis

19a. Informant's Name/Relationship (Type, Print): Annie Rebecca Lewis/Wife
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 11604 Molly Berry Road Upper Marlboro, Maryland 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Myers Church Cemetery | Dete: January 3, 1998
20c. Location - City or Town, State: Upper Marlboro, Maryland

21. Signature of Funeral Service Licensee: Lloyd M. Estep
22. Name and Address of Feciiity: Adams Funeral Home 20605 Aquasco Road Aquasco, Maryland 20608

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only one cause on eech line.

		Approximate Interval Between Onset end Deeth
Immediete Cause (Finei disease or condition resulting in death)	a. CARDIOGENIC SHOCK	8 hrs
Due to (or es e consequence of):	b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
Sequentiaily list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Lest	c. CONGESTIVE HEART FAILURE	
Due to (or es e consequence of):	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings evaiieble prior to completion of ceuse of death? 1 [ ] Yes 2 [X] No

25. Was cese referred to medicel examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Yeer): N/A
28b. Time of Injury: N/A M
28c. Injury et Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: N/A
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): N/A
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete): N/A

29a. Certifier (Check only one): 1 [X] **Certifying Physicien**: To the best of my knowledge, death occurred et the time, date and piece, and due to the ceuse(s) and manner as steted. 2 [ ] **Medical Examiner**: On the basis of exemination end/or investigetion, in my opinion, deeth occurred at the time, dete and place, and due to the ceuse(s) end manner stated.

29b. Signature end titie of certifier: Vicki E. Jeffery MD
29c. License number: D20986
29d. Dete signed (Month, Dey, Yeer): 12-30-97

30. Name end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): 9131 Piscataway Rd CLINTON MARYLAND 20735

State Registrar

31. Date filed (Month, Dey, Yeer): JAN 05 1998
32. Registrar's Signature: Julie Thacker Pardell

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41154

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wilbur James Lewis

2. Date of Death (Month, Day, Year): December 29, 1997

3. Time of Death: 19:23 Hrs

4a. Facility Name (If not institution, give street and number): 183 Darlington Avenue

4b. City, Town, or Location of Death: Aberdeen

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 579-46-6221

6. Sex: 1☒M 2☐F

7. Age (in yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 1, 1938

9. Birthplace (State or Foreign Country): Missouri

Usual Residance of Decadent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Aberdeen

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 183 Darlington Avenue

10f. Zip Code: 21001

10g. Citizen of What Country?: U.S.A.

11. Meritel Stetus: 1☐Never Married 2☒Merried 3☐Widowed 4☐Divorcad

12. Wes Decedent Ever in U,S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Deteil: Korea & Vietnam

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondery (0-12): 12

College (1-4or 5+): 0

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Military

16b. Kind of Businass/Industry: U.S. Army

17. Fether's Neme (First, Middle, Last): UNK

18. Mother's Neme (First, Middle, Maiden Surneme): Esther O'Connor

19a. Informent's Name/Reletionship (Type, Print): Heidemarie B. Lewis (Spouse)

19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code): 183 Darlington Ave., Aberdeen, MD 21001

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from Stete 4☐Donetion 5☐Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Harford Memorial Gardens

Dete: 1/3/98

20c. Location - City or Town, State: Aberdeen, Maryland

21. Signeture of Funerel Service Licensee: Kenneth B. Cargo

22. Neme and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximata Interval Between Onset and Death

Immediete Cause (Finel disease or condition resulting in death)

e. Acute Coronary Artery Disease

Due to (or as a consequence of):

Sequentlelly list conditions, if eny, leeding to Immediete cause. Entar Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last

b. ASCVD

Due to (or as e consequence of):

c.

Due to (or as a consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes an eutopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings availeble prior to completion of cause of death? 1☐Yes 2☒No

25. Was casa referred to medical examiner? 1☒Yes 2☐No

26. Piece of Deeth (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Deeth: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Deta of Injury (Month, Dey Year): NA

28b. Time of Injury: NA M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: NA

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify): NA

28f. Location (Street and Number or Rural Route Number, City or Town, State): NA

29a. Certifier (Check only one): 1☐**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the cause(s) and manner as stated. 2☒**Medical Examiner:** On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: DME

29c. License number: OCME

29d. Dete signed (Month, Day, Year): Dec 30 1997

30. Nama and address of person who completed cause of deeth (Item 29a) (Type, Print): G.S.Prabhu M.D. 218 Fulford Ave Bel Air MD/ 21014 410-879-6564.

State Registrar

31. Dete filed (Month, Dey, Year): DEC 30 1997

32. Registrar's Signeture: Julia Davidson-Randall

DHMH t6 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet tha deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificete has been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Replacement

Reg. No. 97-41155

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Adamson Lacy

2. Date of Death (Month, Day, Year): December 25 1997

3. Time of Death: 10:30 am

4a. Facility Name (If not institution, give street and number): Genesis Eldercare

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 172-22-0155

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 4/30/10

9. Birthplace (State or Foreign Country): PA

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Arnold

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 18 Old Sturbridge Rd.

10f. Zip Code: 21012

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary

16b. Kind of Business/Industry: Family Marine Business

17. Father's Name (First, Middle, Last): Harold Adamson

18. Mother's Name (First, Middle, Maiden Surname): Beatrice Whitham

19a. Informant's Name/Relationship (Type, Print): Phyllis L. Mentzell

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18 Old Sturbridge Rd. Arnold, MD 21012

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crestlawn Memorial Gardens

Date: 12/29

20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Barranco & Sons P.A. Severna Park Funeral Home 495 Ritchie Hwy Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Congestive Heart Failure — 2 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia

Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D31778

29d. Date signed (Month, Day, Year): 1/9/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT MILLER 2003 Medical Parkway Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year): JAN 28 1998

32. Registrar's Signature: Julian Davidson-Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 41156

Item: 5 per Informant G-756 2/21/98 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary G. Lincoln

2. Date of Death (Month, Day, Year): December 23, 1997

3. Time of Death: 7:48 PM

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: ~~105-10-6568~~ ~~105-10-6865~~

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 8, 1908

9. Birthplace *(State or Foreign Country)*: Buffalo, NY

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐ Yes 2☑ No

10e. Street and Number: 30 Ritchfield Court

10f. Zip Code: 20850

10g. Citizen of What Country?: United States of America

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): -4-

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Teacher

16b. Kind of Business/Industry: Education

17. Father's Name *(First, Middle, Last)*: Patrick Daniel Connors

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Gertrude Conway

19a. Informant's Name/Relationship *(Type, Print)*: Paula Lincoln-Smith - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 30 Ritchfield Ct. Rockville, MD 20850

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Elmlawn Cemetery

Date: Dec. 27, 1997

20c. Location - City or Town, State: Tonawanda, New York

21. Signature of Funeral Service Licensee: Karen W. Roberts

22. Name and Address of Facility: John E. Roberts Funeral Home 1361 Hertel Ave Buffalo, NY 14216

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — 3 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

ANEMIA

CHRONIC RENAL FAILURE

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, dete and plece, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: Grace Sagayadam pd

29c. License number: D43358

29d. Date signed *(Month, Dey, Year)*: DECEMBER 24, 1997

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print): Dr. Grace Sagayadan 849-C QUINCE ORCHARD BLVD, GAITHERSBURG, MD 20878

State Registrar

31. Date filed *(Month, Dey, Yeer)*: DEC 30 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41157

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Horace Bruce MOYE

2. Date of Death (Month / Day / Year): Dec 29 97

3. Time of Death: 1425

4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Gen Hosp

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL A.A.

Funeral Director

5. Social Security Number: 240-05-9854

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUGUST 1, 1916

9. Birthplace *(State or Foreign Country)*: NORTH CAROLINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: WALDORF

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2513 LISA DRIVE

10f. Zip Code: 20601

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MANAGER SHOE STORE

16b. Kind of Business/Industry: RETAIL

17. Father's Name *(First, Middle, Last)*: ALONZO MOYE

18. Mother's Name *(First, Middle, Maiden Surname)*: EMMA TYSON

19a. Informant's Name/Relationship *(Type, Print)*: ALBERTA H. MOYE/WIFE

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2513 LISA DRIVE, WALDORF, MARYLAND 20601

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory, or other place)*: MD. VETERANS' CEMETERY

Date: JAN.7,1998

20c. Location - City or Town, State: CHELTENHAM, MARYLAND

21. Signature of Funeral Service Licensee: Shannon W. Ramirez

SHANNON W. RAMIREZ M00798

22. Name and Address of Facility: THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Heart Disease UNK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: William P. Jones Deputy

29c. License number: D06054

29d. Date signed *(Month, Day, Year)*: 12/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William P. Jones, MD 695 America 21035

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1998

32. Registrar's Signature: Julia Strickland Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 4 1158

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ABDULLAH MUHAMMAD
2. Date of Death Month Day Year: 12-28-97
3. Time of Death: 6:00pm
4a. Facility Name (If not institution, give street and number): 7116 DUCKETTS LA. #104
4b. City, Town, or Location of Death: ELKRIDGE
4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: 211-42-2812
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 46 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-3-51
9. Birthplace (State or Foreign Country): PENN

Usual Residence of Decedent

10a. State: Maryland
10b. County: HOWARD
10c. City, Town or Location: ELKRIDGE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 7116 DUCKETTS LA. #104
10f. Zip Code: 21075
10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CHAPLIN
16b. Kind of Business/Industry: PRISON

17. Father's Name (First, Middle, Last): CARL M. HACKNEY SR.
18. Mother's Name (First, Middle, Maiden Surname): ANITA MOORE-HACKNEY

19a. Informant's Name/Relationship (Type, Print): BRENDA HACKNEY MUHAMMAD
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7116 Ducketts La.,Elkridge,Md. 21075

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Kings Memorial Park
Date: 12-31-97
20c. Location - City or Town, State: Randallstown,Md.

21. Signature of Funeral Service Licensee: Paul de Mateo
22. Name and Address of Facility: UNIVERSAL MORTUARY INC. 411 KENNEDY ST,N.W., WASHINGTON,D.C.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Disease — years

Due to (or as a consequence of):
b. Hypertension — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Diabetes mellitus — year

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] ~~Yes~~ 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Patrice A Toye, MD Deputy ME
29c. License number: D31473
29d. Date signed (Month, Day, Year): Dec 29, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRICE A TOYE, MD 4565 Hemlock Cone Way Ellicott City MD 21042

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998
32. Registrar's Signature: Julia Saunders Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

P 6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 41159

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALBERT ALEXANDER McCAIN

2. Date of Death Month Day Year: DEC. 26, 1997

3. Time of Death: 6:45AM

4a. Facility Name (If not institution, give street and number): 401 Peppermill Dr

4b. City, Town, or Location of Death: Capitol Hgts MD

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 238-56-2772

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 17, 1938

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Md.

10b. County: Prince Georges

10c. City, Town or Location: Capitol Heights

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 401 Peppermill Drive

10f. Zip Code: 20743

10g. Citizen of What Country? USA

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☐No If Yes, Give Year or Dates: XX

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Manager

16b. Kind of Business/Industry: Parking Lot

17. Father's Name (First, Middle, Last): Coutelyous McCain

18. Mother's Name (First, Middle, Maiden Surname): Alice Crawley

19a. Informant's Name/Relationship (Type, Print): Nora McCain (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 401 Peppermill Dr., Capitol Hgts, Md. 20743

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Removal from State

Date: 12/28/97

20c. Location - City or Town, State: Roxsboro, N.C.

21. Signature of Funeral Service Licensee: Ralph Williams

22. Name and Address of Facility: Ralph Williams Funeral Service 517 - 11th Street, S.E.; Wash., DC

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. metastatic lung cancer — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert M. Hershaw MD

29c. License number: D0052431

29d. Date signed (Month, Day, Year): 12/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert M. Hershaw MD 110 Irving St NW Washington DC 20010

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998

32. Registrar's Signature: John Thompson Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

16

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 17 Per FH Film G756 2-2-98 rja

Certificate of Death

Reg. No. 97 41160

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LILLIE H. MAYER

2. Date of Death Month Day Year: DEC. 21, 1997

3. Time of Death: 5:55 PM

4a. Facility Name *(If not institution, give street and number)*: NATIONAL LUTHERAN HOME

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY CO.

Funeral Director

5. Social Security Number: 213-05-6844

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: SEPT.6,1908

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD.

10b. County: MONTGOMERY CO.

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1908- ELKHART STREET

10f. Zip Coda: 20910

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Spacify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: AT HOME

17. Father's Name *(First, Middle, Last)*: GEORGE WALTER NORRIS ~~GRACE W. NORRIS~~

18. Mother's Name *(First, Middle, Maiden Surname)*: LILLIE E. LIEBNO

19a. Informant's Name/Relationship *(Type, Print)*: MR.VERNON MAYER,JR.-SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 121-Applewood La., Slippery Rock,Pa.16507

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: METROPOLITAN CREMATORY-12/26

Date

20c. Location - City or Town, State: -ALEXANDRIA, VA.

21. Signature of Funeral Service Licensee: W. M. Hysong

22. Name and Address of Facility: HYSONG CO.,INC. FUNERAL HOME 1300- N ST., NW, WASH.,DC 20005

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Ischemic Bowel Disease — 5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Carotid Artery Disease — 20 years

Due to (or as a consequence of):

c. Peripheral Vascular Disease, Atherosclerotic — 30 years

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Amputation Above the Knee 1975, Dysphagia Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to complation of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residance 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturat 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Schemm M.D.

29c. License number: D36618

29d. Date signed *(Month, Day, Year)*: December 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR.C. SCHEMM- 9701- VEIRS DR., ROCKVILLE,MD. 20850

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 29 1997

32. Registrar's Signature: Sofia Olivares Parlett

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41161

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Jenice S. Massey
2. Date of Death (Month, Day, Year): December 20, 1997
3. Time of Death: 5:30 AM
4a. Facility Name (If not institution, give street and number): Manor Care
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 246-52-3452
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 11, 1934
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Bowie
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14909 Jenkins Ridge Road
10f. Zip Code: 20721
10g. Citizen of What Country: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Black, Whita, atc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Aide
16b. Kind of Businass/Industry: Transportation

17. Father's Nama (First, Middle, Last): Fred Shufford
18. Mother's Name (First, Middle, Maiden Surname): Bessie Beatty

19a. Informant's Name/Relationship (Type, Print): Miriam M. Reid-Daughter
19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code): 14909 Jenkins Ridge Road, Bowie, Maryland 20721

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cematary, crematory or other place): Fort Lincoln Cemetery
Date: 12-27-97
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Lisa S. Johnson
22. Nama and Address of Facility: Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, Maryland 20722

Physician /Medical Examiner

23a. Part I. Enter the diseasa, or complications that causad the death. Do not entar tha mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in deeth) a.	Breast Cancer with Metastasis	2 years
Due to (or as a consequence of): b.		
Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Was cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Placa of Deeth (Check only one): Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29a. Certifiar (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D21430
29d. Date signed (Month, Day, Year): December 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John MARGOLIS 14333 Laurel-Bowie Road, Laurel, Maryland 20708

State Registrar

31. Dete filed (Month, Day, Year): DEC 29 1997
32. Registrar's Signature: Jobi Henderson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41162

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Robert Richard McHale

2. Dete of Deeth — Month: December; Dey: 28; Yeer: 1997

3. Time of Deeth: 8:35 pm

4e. Feciliity Neme *(If not institution, give street end number)*: Doctors Community Hospital

4b. City, Town, or Location of Deeth: Lanham

4c. County of Deeth: Prince George's

Funeral Director

5. Social Security Number: 579-20-8874

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months; Deys

If Under 24 Hrs.: Hours; Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Nov. 29, 1923

9. Birthplece *(Stete or Foreign Country)*: New York

Usuei Residence of Decedent

10a. Stete: Maryland

10b. County: Prince George's

10c. City, Town or Location: Riverdale

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 5508 59th Avenue

10f. Zip Code: 20737

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1943-1945

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - American indien, Bieck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12); College (1-4or 5+): 1½

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Bricklayer

16b. Kind of Business/Industry: Union Bricklayer

17. Fether's Neme *(First, Middle, Last)*: Thomas McHale

18. Mother's Neme *(First, Middle, Maiden Surneme)*: Louise Miller

19e. Informent's Neme/Reletionship *(Type, Print)*: Dolores V. McHale

19b. Melling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 5508 59th Avenue, Riverdale, Maryland 20737

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: Fort Lincoln Cemetery

Dete: 12/31/97

20c. Location - City or Town, Stete: Brentwood, Maryland

21. Signeture of Funeral Service Licensee: Claudette L. Gasch

22. Neme end Address of Feciliity: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete intervei Between Onset end Death

Immediete Ceuse (Finei disease or condition resulting in deeth)

e. ACUTE MYOCARDIAL INFARCTION

Due to (or es a consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last

b. CORONARY ATHEROSCLEROSIS

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Pert ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

HYPERCHOLESTROLEMIA

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probebly 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveiieble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medicai exeminer? 1☐ Yes 2☒ No

28. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☒ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturei 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, dete end pieca, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier:

29c. License number: D04841

29d. Date signed *(Month, Dey, Yeer)*: 12,29 97

30. Neme end eddress of person who completed cause of deeth (item 23e) (Type, Print): Mehdi P. Farzin, M.D. 7525 Greenway Center Drive, T-3, Greenbelt, MD 20770

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 30 1997

32. Registrar's Signeture: Julia Denham-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41163

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SUSAN A. MUSGROVE

2. Date of Death (Month, Day, Year): DECEMBER 26, 1997

3. Time of Death: 11:33 PM

4a. Facility Name (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 228-68-0901

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 49 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 1-19-48

9. Birthplace (State or Foreign Country): PITTSYLVANIA CO. VA.

Usual Residence of Decedent

10a. State: MD.

10b. County: Prince George

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4905 DECATUR ST.

10f. Zip Code: 20781

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12+H | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): GENERAL MANAGER

16b. Kind of Business/Industry: Murray's Corp.

17. Father's Name (First, Middle, Last): CHARLIE MUSGROVE

18. Mother's Name (First, Middle, Maiden Surname): EVA WITCHER

19a. Informant's Name/Relationship (Type, Print): EDNA M. MUSGROVE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1000 Corner Rd., Java, Va. 24565

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MEASE Cemetery

Date: 1-1-98

20c. Location - City or Town, State: Sandy Level, VA.

21. Signature of Funeral Service Licensee: Sarah Branch

22. Name and Address of Facility: B.K. HENRY Funeral Chapel, Inc. 420-H St. N.E., Wash. D.C. 20002

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier: Mario F. Golle Jr MD

29c. License number: DME D 33954

29d. Date signed (Month, Day, Year): DECEMBER 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F. GOLLE JR MD, 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997

32. Registrar's Signature: Julia Thurston-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41164

4 0/4

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
RAMON	MARTIN	December 29 1997	6:50 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
WASHINGTON ADVENTIST HOSPITAL	Takoma Park	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
None	1[X] M 2[ ] F	90 Yrs.			August 31, 1907	Trinidad

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1[X] Yes 2[ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
9300 Piney Branch Road #T-12	20903	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yas, specify Cuban, Mexican, Puarto Rican, atc.)	14. Race - American Indian, Black, White, etc.
1[ ] Navar Married 2[ ] Married 3[X] Widowed 4[ ] Divorced	1[ ] Yes 2[X] No If Yas, Giva Year or Datas:	1[ ] Yas 2[X] No Specify:	Specify: Black

15. Decedent's Education (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired)	16b. Kind of Businass/Industry
Elamantary/Secondary (0-12)	Collaga (1-4or 5+)		
12		Printer	Private

17. Father's Name (First, Middla, Last)	18. Mothar's Nama (First, Middla, Maidan Sumama)
(unk) Martin	(unk)

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Addrass (Straet and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
Rita M. George - Daughter	9300 Piney Branch Rd #T12 Silver Spring, Md 20903

20a. Method of Disposition	20b. Placa of Disposition (Nama of cematary, cramatory or othar placa)	Data	20c. Location - City or Town, Stata
1[X] Burial 2[ ] Cramation 3[ ] Ramoval from Stata 4[ ] Donation 5[ ] Othar (Specify)	Ft. Lincoln Cemetery	1/3/98	Brentwood, Maryland

21. Signatura of Funaral Service Licensaa		22. Name and Address of Facility
Alex S Pope Jr	M859	ALEXANDER S. POPE FUNERAL HOMES 2617 Pennsylvania Avenue, SE DC 20020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the daath. Do not enter tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

		Approximata Interval Batwaen Onset and Death
Immediata Causa (Finai disaasa or condition rasulting in daath)	a. Pneumonia	Days
	Dua to (or as a consaquanca of): b. Urinary Tract Infection	Days
Saquantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last	Due to (or as a consaquanca of): c. Cardiac Dysrhythmia	Days
	Due to (or as a consaquanca of): d. Sepsis	Days

Part ii. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part i.

23b. **Did tobacco use contribute to the cause of death?** 1[ ] Yes 2[ ] No 3[ ] Probably 4[✓] Unknown

24a. Was an autopsy performed?	24b. Ware autopsy findings available prior to complation of causa of daath?
1[ ] Yas 2[✓] No	1[ ] Yas 2[ ] No

25. Was casa rafarrad to medical examinar?	26. Placa of Death (Check only ona)	
1[ ] Yas 2[✓] No	Hospital: 1[✓] Inpatiant 2[ ] ER/Outpatiant 3[ ] DOA	Othar: 4[ ] Nursing Homa 5[ ] Residanca 8[ ] Othar (Specify)

27. Manner of Death	28a. Data of injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1[✓] Naturai 2[ ] Accidant 3[ ] Sulcida 4[ ] Homicida 5[ ] Panding investigation 6[ ] Could not be datarmined		M	1[ ] Yas 2[ ] No	
	28a. Placa of injury - At homa, farm, straat, factory, office building, atc. (Specify)			28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Cartifiar (Check only one) 1[✓] **Certifying Physician:** To tha bast of my knowledga, daath occurred at tha tima, data and placa, and due to tha cause(s) and mannar as statad.
2[ ] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licansa number	29d. Date signed (Month, Day, Year)
Farzad Assar M.D.	D-40201	DECEMBER 29, 1997

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print)
FARZAD ASSAR, M.D. 19251 MONT. VILLAGE AVE., GAITHERSBURG MD 20879

State Registrar

31. Data filed (Month, Day, Yaar) DEC 31 1997 — Registrar's Signatura: Julia Hunter Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41165

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY H. MARTIN
2. Date of Death: Month December Day 30 Year 1997
3. Time of Death: 6:59 AM
4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-32-0990
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 17, 1925
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Cheverly
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6011 State Street
10f. Zip Code: 20785
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 1 year
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Customer Service Manager
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Luther Headen
18. Mother's Name (First, Middle, Maiden Surname): Katie Smith

19a. Informant's Name/Relationship (Type, Print): Paul C. Martin/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6011 State Street, Cheverly, Maryland 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park
Date: 01/03 1998
20c. Location - City or Town, State: Landover, Maryland

21. Signature of Funeral Service Licensee: ▶ Nancy A. Pencantic
22. Name and Address of Facility: J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC CARCINOMATOSIS

Due to (or as a consequence of): b.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d. CARCINOMA OF THE LUNGS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Don B Cameron MD.
29c. License number: D 01808
29d. Date signed (Month, Day, Year): 12-30-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DON B. CAMERON, M.D. 6005 LANDOVER RD CHEVERLY, MD 20785

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997
32. Registrar's Signature: Julia Marilyn Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41166

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alice Murray

2. Date of Death — Month: 12 Day: 24 Year: 97

3. Time of Death: 12:20 PM

4a. Facility Name *(If not institution, give street and number)*: Prince George's Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 215-13-8820

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 04-05-12

9. Birthplace *(State or Foreign Country)*: Jamaica, W.I.

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Mitchellville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 11104 Mission Hills

10f. Zip Code: 20721

10g. Citizen of What Country?: Jamaica, W.I.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): — College (1-4or 5+): 4+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Robert Newman

18. Mother's Name *(First, Middle, Maiden Surname)*: Edith Foster

19a. Informant's Name/Relationship *(Type, Print)*: George Murray/Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11104 Mission Hills, Mitchellville, Maryland 20721

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Donecot Cemetery — Date: 01/07 1998

20c. Location - City or Town, State: St Catherine, Jamaica, W.I.

21. Signature of Funeral Service Licensee: ▶ Nancy A. Percentie

22. Name and Address of Facility: J. B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. cerebral vascular accident — days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)* — Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D41978

29d. Date signed *(Month, Day, Year)*: 12-29-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nader Tawakoli, M.D PGH Cheverly M.D 20785

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 31 1997

32. Registrar's Signature: ▶ John Meredith Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41167

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Paul Robert McCusker
2. Date of Death Month / Day / Year: DECEMBER 24, 1997
3. Time of Death: 1735
4a. Facility Name *(If not institution, give street and number)*: Sacred Heart Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 567-14-8212
6. Sex: 1 X M 2 ☐ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Day, Year)*: May 1, 1917
9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 16115 Orchard Mews
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Maritel Stetus: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No — If Yes, Give Year or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 X No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: painter
16b. Kind of Business/Industry: painting

17. Father's Neme *(First, Middle, Last)*: Joseph H. McCusker
18. Mother's Name *(First, Middle, Maiden Surname)*: Flora A. Wilkins

19e. Informant's Name/Relationship *(Type, Print)*: Eleanora McCusker, wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 16115 Orchard Mews Apt 201; Cumberland, MD 21502

20a. Method of Disposition: 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cumberland Crematory
Date: 12/26
20c. Location - City or Town, State: Cumberland, MD

21. Signature of Funeral Service Licensee: ▶ James J Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Respiratory failure — 18 day
Due to (or as a consequence of):
b. pneumonia — 18 day
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Acute Renal failure — 10 days
Due to (or as a consequence of):
d. Hypotension — 10 day

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Coronary artery disease
Chronic obstructive lung disease
Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 X No

25. Was case referred to medical exeminer? 1 ☐ Yes 2 X No
Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
26. Place of Death *(Check only one)*: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Menner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D15463
29d. Date signed *(Month, Day, Year)*: DECEMBER 25 1997
30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Dr. S. Kam, M.D.; 900 Seton Drive; Cumberland, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 2 8 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41168

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: RALPH OLIVER MOTT

2. Dete of Deeth — Month: DEC Day: 29 Year: 1997

3. Time of Death: 10:45 AM

4a. Fecility Name *(If not institution, give street end number)*: AMTRAK TRAIN

4b. City, Town, or Location of Deeth: CUMBERLAND

4c. County of Deeth: ALLEGANY

Funeral Director

5. Social Security Number: 446-20-0056

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthdey)*: 94 Yrs.

If Under 1 Year — Months: Deys: If Under 24 Hrs. — Hours: Min.:

8. Dete of Birth *(Month, Dey, Yeer)*: MAY 30 1903

9. Birthplece *(Stete or Foreign Country)*: IOWA

To Be Completed by Funeral Director

Usual Residence of Decedent

10e. Stete: ARKANSAS

10b. County: SEBASTIAN

10c. City, Town or Location: FORT SMITH

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 1104 SOUTH 26th STREET

10f. Zip Code: 72901

10g. Citizen of Whet Country?: U.S.A.

11. Merital Stetus: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - Americen Indien, Bleck, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12+ College (1-4or 5+): 4

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: ARCHITECT

16b. Kind of Business/Industry: ARCHITECT

17. Fether's Nema *(First, Middle, Last)*: FRANK OLIVER MOTT

18. Mother's Name *(First, Middle, Meiden Surneme)*: PEARL GREENE

19a. Informent's Neme/Reletionship *(Type, Print)*: JOHN K. MOTT SON

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 7903 TURNCREST DRIVE POTOMAC, MARYLAND 20854

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other place)*: FOREST PARK CEMETERY Date: JAN 3 1998

20c. Location - City or Town, Stete: FORT SMITH, ARKANSAS

21. Signeture of Funeral Service Licensee: Dale L. Merritt

22. Neme end Address of Facility: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cerdiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Intervel Between Onset end Deeth

Immediete Cause (Final disease or condition resulting in deeth) e. pneumonia — 48 hours

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to Immedieta ceusa. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceusa given in Part I.: severe kyphosis osteoporosis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings aveileble prior to completion of ceusa of deeth? 1 [ ] Yes 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes cese referred to medicel exeminer? 1 [X] Yes 2 [ ] No

26. Pleca of Deeth *(Check only one)*: Hospital: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* RAILROAD CAR

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) end menner es steted. 2 [X] **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) and menner steted.

29b. Signeture and title of certifier: Donald Monge MD DMI

29c. Licensa number: D09231

29d. Date signed *(Month, Dey, Yeer)*: DEC 29 1997

30. Neme end address of person who completed ceuse of deeth (Item 23e) (Type, Print): DONALD MANGE DME MD 11600 Rockville Pk Rockville MD.

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 30 1997

32. Registrar's Signeture: Julie Director Rockett

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10 BK

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41169

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: THOMAS L. MORGAN
2. Dete of Deeth Month Dey Year: DECEMBER 31, 1997
3. Time of Death: 0130
4a. Facility Name *(If not institution, give street end number)*: SACRED HEART HOSPITAL
4b. City, Town, or Location of Deeth: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 220-16-2526
6. Sex: 1 X M 2 ☐ F
7. Age *(In yrs. last birthday)*: 71 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Oct 15, 1926
9. Birthplace *(Stete or Foreign Country)*: MD

Usual Residence of Decedant

10e. State: MD
10b. County: Allegany
10c. City, Town or Location: Cresaptown
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 12810 McKay Drive SW
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Merital Stetus: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Detes: WW II
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No *Specify:*
14. Race - American indian, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grede completed)*: Elamantary/Secondery (0-12): 12 / College (1-4or 5+):
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Retired Bartender
16b. Kind of Business/Industry: Cresap Tavern

17. Fether's Neme *(First, Middle, Last)*: Albert Morgan, Sr.
18. Mother's Nama *(First, Middle, Maiden Sumeme)*: Ada (Howsare)

19e. Informant's Name/Relationship *(Type, Print)*: Sandy Twigg—daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: Route 1 Box 192A; Ridgeley, WV 26753

20a. Method of Disposition: 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Neme of cemetery, crematory or other piece)*: Rocky Gap Veterans Cem
Date: 01/05
20c. Location - City or Town, State: Flintstone, MD

21. Signature of Funeral Service Licensee: ▶ Nicholas J Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Respiratory Failure — One month
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b. Chronic Obstructive Pulmonary Dis. — 10 years
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cor Pulmonale; Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No
26. Place of Death *(Check only one)*: Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; Other: 4 ☐ Nursing Home 5 ☐ Residance 6 ☐ Other *(Specify)*
27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ R Fadl M.D.
29c. License number: 16150
29d. Date signed *(Month, Day, Year)*: DECEMBER 31, 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print): R. Fadl, M.D.; 921 Seton Drive; Cumberland, MD 21502

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State Registrar

31. Date filed *(Month, Dey, Yeer)*: DEC 31 1997
32. Registrar's Signature: ▶ Julia [illegible]

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41170
Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JENNIE REED DUCKWORTH MC KENZIE
2. Date of Death — Month: DEC Day: 31 Year: 1997
3. Time of Death: 12:15 AM
4a. Facility Name *(If not institution, give street and number)*: FROSTBURG VILLAGE NURSING HOME
4b. City, Town, or Location of Death: FROSTBURG
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 217-10-7980
6. Sex: 1☐ M 2☐ F
7. Age *(In yrs. last birthday)*: 78 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: MARCH 15, 1919
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: WEST VIRGINIA
10b. County: MINERAL
10c. City, Town or Location: RIDGELEY
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: RT 1 BOX 192B
10f. Zip Code: 26753
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE
16b. Kind of Business/Industry: OWN HOME

17. Father's Name *(First, Middle, Last)*: GEORGE DUCKWORTH
18. Mother's Name *(First, Middle, Maiden Surname)*: MARGARET ELIZABETH O'DAY

19a. Informant's Name/Relationship *(Type, Print)*: ANTHONY W. MC KENZIE, HUSBAND
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: RT 1 BOX 192B, RIDGELEY, WV 26753

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cramatory or other place)*: ROCKY GAP VETERANS CEMETERY — Date: JAN 5, 1997
20c. Location - City or Town, State: FLINTSTONE, MARYLAND

21. Signature of Funeral Service Licensee: ▶ Douglas A Hafer
22. Name and Address of Facility: HAFER CHAPEL OF THE HILLS MORTUARY 1302 NATIONAL HWY, LA VALE, MD 21502

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CEREBRAL INFARCTION — ONE DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CONGESTIVE HEART FAILURE
PARKINSONS DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaicien:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Chang Hyun K MD
29c. License number: D24951
29d. Data signed *(Month, Day, Year)*: Dec 31, 97

30. Name and address of person who completed cause of death (item 23a) (Type, Print): CHANG H. OH, MD, 48 TARN TERRACE, FROSTBURG, Md 21532

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3 pgs

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998
32. Registrar's Signature: ▶ [signature]

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 4171

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Belinda Miller	December 30, 1997	6:00 P.M.

4a. Facility Name (If not Institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Cuppett & Weeks Nursing Home	Oakland	Garrett

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
166-50-7520	1☐ M 2☒ F	93 Yrs.			December 6, 1904	Pennsylvania

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Garrett	Oakland	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
706 E. Alder St.	21550	U.S.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
8		Housewife	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Irvin Meyers	Susan Custer

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Glenn A. Miller / Son	481 Covered Bridge Rd., Stoystown, PA 15563

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Walker Cemetery	January 3, 1998	Shanksville, PA

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Donald L. Deaner	Deaner Funeral Home, Inc., Stoystown, PA 15563-0555

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. acute bronchitis	6 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

atherosclerotic cardiovascular disease

senile onset dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Walter K. Naumann M.D.	D25759	December 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Walter K. Naumann, M.D., PO Box 247, 106 Cemetery Rd, Accident MD 21520

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 05 1998	

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41172

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HAROLD E. MARCUM

2. Date of Death Month / Day / Year: DECEMBER 17 1997

3. Time of Death: 4:48 PM

4e. Facility Name *(If not Institution, give street and number)*: Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 291-01-3428

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 1/16/1907

9. Birthplace *(State or Foreign Country)*: Illinois

Usual Residence of Decedent

10e. State: MD

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1300 A. Sheridan Place

10f. Zip Code: 21014

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Unknown; College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Rubber worker

16b. Kind of Business/Industry: Manufacturing

17. Father's Name *(First, Middle, Last)*: H.B. Marcum

18. Mother's Name *(First, Middle, Maiden Surname)*: Myrtle Light

19e. Informant's Name/Relationship *(Type, Print)*: Jane Y. Marcum - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1300 A. Sheridan Place, Bel Air, MD

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crown Hill Mem. Park

Date: 12/22

20c. Location - City or Town, State: Twinsburg, OH

21. Signature of Funeral Service License: Jeffrey L. Swales

22. Name and Address of Facility: Harkins Funeral Home, Inc., Delta, PA

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

MARCUM Harold E

Up

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — 15 HOURS

Due to (or as a consequence of):

b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: R. Phillips

29c. License number: D22843

29d. Date signed *(Month, Day, Year)*: DECEMBER 18 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): R. PHILLIPS 2005 ROCK SPRING RD FOREST HILL MD 21050

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

14+1

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 23 1997

32. Registrar's Signature: Judi Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41173

Physician /Medical Examiner

1. Decadant's Nama (First, Middle, Last): Margaret Anna Marshall

2. Data of Death — Month: December Day: 31 Yaar: 1997

3. Tima of Death: 2050

4a. Facility Nama (If not institution, give street and number): Union Hospital of Cecil County

4b. City, Town, or Location of Daath: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 217-78-0895

6. Sex: 1☐ M 2☒ F

7. Aga (In yrs. last birthday): 81 Yrs.

If Undar 1 Yaar — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Year): January 26, 1916

9. Birthpleca (State or Foreign Country): Maryland

Usuel Rasidanca of Dacedant

10a. Stata: Maryland

10b. County: Cecil

10c. City, Town or Location: Rising Sun

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street end Number: 1881 Telegraph Road

10f. Zip Coda: 21911

10g. Citizen of Whet Country?: United States

11. Maritel Status: 1☐ Naver Marriad 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Dacadent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Dates:

13. Was Dacedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Black, Whita, atc. Specify: White

15. Dacadant's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 College (1-4or 5+):

16a. Dacadant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Her own Home

17. Fathar's Nama (First, Middle, Last): Marvin Jones

18. Mothar's Nama (First, Middle, Meiden Surname): Edna Dewald

19a. Informant's Name/Ralationship (Type, Print): Claudette Kazmaier / Daughter

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 99A Wells Camp Road, North East, MD 21901

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramovel from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Plece of Disposition (Name of cemetery, crematory or other piece): Holy Redeemer Cemetery

Data: Jan. 5 1998

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Robert H. Crouch

22. Nama and Address of Facility: Crouch Funeral Home 127 South Main Street, North East, MD 21901

Physician /Medical Examiner

23a. Part1. Enter the diseesa, or complicetions that caused the daath. Do not anter the moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximete Intarval Batwaan Onset and Death

Immadiata Causa (Final disaase or condition resulting in daath)

e. Uro Sepsis — <2 wks

Due to (or as a consequence of):

Sequantially list conditions, if eny, leading to Immadiata cause. Enter Underlying Causa (Disease or Injury that initiatad avants resulting in daath) Last

b. Renal Nephrolithiasis, Obstruction (L) — >1 year

Due to (or as a consequence of):

c.

Due to (or es a consaquanca of):

d.

Part II. Other significant conditions contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to complation of cause of deeth? 1☐ Yas 2☐ No

25. Was case refarrad to medical examinar? 1☐ Yas 2☒ No

26. Plece of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residenca 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not ba datarmined

28a. Data of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurrad

28e. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To tha best of my knowladga, daath occurred at tha time, date and pleca, and due to the cause(s) and mannar as stated. 2☐ Medical Examinar: On tha basis of examinetion and/or investigation, in my opinion, daeth occurred at tha time, deta and placa, and dua to tha cause(s) and manner stetad.

29b. Signature and title of certifier: Julia B. Calderon MD

29c. License number: D37916

29d. Data signed (Month, Day, Year): 1-2-1998

30. Name end address of person who completed causa of daeth (Item 23a) (Type, Print): 223 W. Main St. Elkton MD

State Registrar

31. Data filad (Month, Day, Year): JAN 06 1998

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Marsha N. Margret

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41174

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary B. Moore

2. Date of Death Month Day Year: December 21, 1997

3. Time of Death: 11:00 AM

4a. Facility Name *(If not institution, give street and number)*: Pleasant Living Convalescent Center

4b. City, Town, or Location of Death: Edgewater

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 229-34-6574

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 23, 1910

9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residance of Decedant

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Edgewater

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 144 Washington Road

10f. Zip Code: 21037

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yes, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Legal Secretary

16b. Kind of Business/Industry: Federal Government

17. Fathar's Nama *(First, Middle, Last)*: David Brand

18. Mothar's Nama *(First, Middle, Maidan Sumama)*: Mary Ann Petrie

19a. Informant's Name/Ralationship *(Type, Print)*: Mary Patricia Peck/ Daughter

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 530 Coover Road Annapolis, Maryland 21401

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or othar place)*: Metropolitan Crematory Data: 12-22-97

20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signature of Funeral Service Licensee: ▶ [signature]

22. Nama and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md. 21037

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not entar tha moda of dying, such as cardiac or raapiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximate Interval Between Onset and Death

Immediata Cause (Final disaasa or condition rasulting in daath)
a. Left Cerebral Vascular Accident — 5 years

Dua to (or aa a consequence of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last
b.

Dua to (or aa a consequance of):
c.

Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopay performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yaa 2☒ No

28. Placa of Death *(Check only ona)*: Hospital: 1☐ inpatiant 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Homa 5☐ Rasidance 8☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of injury *(Month, Day Year)*

28b. Tima of injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowlaga, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, daath occurrad at the tima, data and placa, and due to tha causa(s) and mannar stated.

29b. Signature and title of cartifiar: ▶ [signature]

29c. Licansa number: D38563

29d. Data signed *(Month, Day, Year)*: December 22 1997

30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): Wayne D. Bierbaum 134 Owensville Rd West River, MD 20778

State Registrar

31. Data filad *(Month, Day, Year)*: DEC 23 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41175

DORIS MARINER

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DORIS MARIE MARINER
2. Date of Death Month Day Year: December 25, 1997
3. Time of Death: 1:50AM
4a. Facility Name (If not institution, give street and number): STELLA MARIS HOSPICE AT MERCY
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death:

Funeral Director

5. Social Security Number: 212-12-7629
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 79 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): SEPT. 9, 1918
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8075 BUDDING BRANCH ROAD APT 12
10f. Zip Code: 21061
10g. Citizen of What Country?: U.S.A

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): EXECUTIVE SECRETARY
16b. Kind of Business/Industry: OIL COMPANY

17. Father's Name (First, Middle, Last): LOUIS HARRY ROBINSON
18. Mother's Name (First, Middle, Maiden Surname): MARIE KLINE

19a. Informant's Name/Relationship (Type, Print): LYNN WHEELER (NIECE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3354 SIMMONS DRIVE GROVE CITY, OHIO 43123

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): DRUID RIDGE CEMETERY
Date: 12-30-97
20c. Location - City or Town, State: BALTIMORE, MD

21. Signature of Funeral Service Licensee: Michael L. Saffell
22. Name and Address of Facility: SINGLETON FUNERAL HOME, PA. 1 SECOND AVENUE , S.W., GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC OVARIAN CANCER — 7 years

Due to (or es a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Lest

b.

Due to (or as a consequence of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): STELLA MARIS AT MERCY
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) HOSPICE

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medicaf Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner sfeted.

29b. Signature and title of cartifier: M. Ramos
29c. Licanse number: D40480
29d. Date signed (Month, Day, Year)

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print): FERNANDO V. FERRO, MD — 7672 Dalsia Rd Balto, MD 21236

State Registrar

31. Dete filed (Month, Day, Year): DEC 30 1997
32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41176

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anthony Kevin McDonald, Jr.

2. Data of Death Month Day Year: December 29, 1997

3. Time of Death: 8:10 pm

4a. Facility Name (If not institution, give street and number): Annapolis Nursing & Rehabilitation Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 219-16-0920

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): June 6, 1924

9. Birthplace (State or Foreign Country): California

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 610 Americana Dr. Apt. 106

10f. Zip Code: 21403

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yaar or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexicen, Puarto Ricen, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Amateur Golfer

16b. Kind of Business/Industry: Golf Club/Self Employe

17. Father's Nama (First, Middle, Last): Anthony McDonald

16. Mother's Name (First, Middle, Maiden Surname): Catherine Conroy

19a. Informant'a Name/Relationship (Type, Print): Mary F. McDonald (wife)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 610 Americana Dr. Apt. 106 Annapolis, Md. 21403

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cramatory or other pleca): Ft. Lincoln Crematory

Date: 12-31-97

20c. Location - City or Town, Stata: Brentwood, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Addrass of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disaasa, or complications that caused the death. Do not antar tha mode of dying, auch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer — 4 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequanca of):

d.

Part II. **Other significant condftions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performad? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, streat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier: R. I. Hochman, M.D.

29c. License number: D05192

29d. Data signed (Month, Day, Year): 12/30/97

30. Name and address of persón who completed cause of death (item 23a)-(Type, Print): Richard I. Hochman, M.D. 1833A Forest Dr. Annapolis, Md. 21401

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41177

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HENRY McCARY

2. Date of Death Month: DEC Day: 29 Year: 97

3. Time of Death: 7PM

4a. Facility Name *(If not institution, give street and number)*: ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: AA

Funeral Director

5. Social Security Number: 577 03 4407

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 31, 1916

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: AA

10c. City, Town or Location: ANNAPOLIS

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 100 GREENSPRING DRIVE

10f. Zip Code: 21403

10g. Citizen of What Country?: US

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Electrician

16b. Kind of Business/Industry: Naval Ordinance Lab

17. Father's Name *(First, Middle, Last)*: Henry Byron McCary

18. Mother's Name *(First, Middle, Maiden Surname)*: Sadie Stull

19a. Informant's Name/Relationship *(Type, Print)*: Tom W. McCary (son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 914 Bayside Dr. Stevensville, Md. 21666

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Cedar Hill Cemetery Date: Jan. 2, 1998

20c. Location - City or Town, State: Brooklyn, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. LYMPHOMA — 4 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D16354

29d. Date signed *(Month, Day, Year)*: 12/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Enser W. Cole III 900 Bestgate Rd, #200 Annapolis.

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 31 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41178

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ENDIA J NIPPER
2. Deta of Death Month Day Year: Dec 23, 1997
3. Time of Death: 1:45 A.m.
4a. Facility Neme (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Deeth: Prince George's

Funeral Director

5. Social Security Number: 249-52-1405
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Yaar: Months / Deys | If Under 24 Hrs.: Hours / Min.
6. Date of Birth (Month, Dey, Year): Sept 13, 1916
9. Birthpleca (State or Foreign Country): Edgefield Co, SC.

Usuel Residanca of Decedent

10e. Stete: md
10b. County: Prince Georges
10c. City, Town or Location: Clinton
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street end Number: 3306 Clavier Place
10f. Zip Code: 20735
10g. Citizan of Whet Country?: United States
11. Marital Stetus: 1☐ Nevar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedant Evar in U.S. Armad Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detas:
13. Was Decedent of Hispenic Origin? (Specify Yas or No- if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Raca - American Indien, Bleck, White, atc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 10th; College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Private
17. Fether's Neme (First, Middle, Last): Jacob Jackson
18. Mother's Neme (First, Middle, Meiden Surname): Endia Mckie
19a. Informent's Neme/Reletionship (Type, Print): Johnnie Nipper
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 3306 Clavier PL Clinton, Md 20735
20a. Method of Disposition: 1☐ Buriel 2☐ Cramation 3☒ Removal from State 4☐ Donation 5☐ Othar (Specify)
20b. Pleca of Disposition (Neme of cemetery, cremetory or othar place): G.L. Brightharp Fun.Home
Dete: 12/26/97
20c. Location - City or Town, Stete: Augusta, So.Carolina
21. Signeture of Funerel Servica Licensee: Alex S Pope Jr 1859
22. Neme end Addrass of Facility: ALEXANDER S. POPE FUNERAL HOMES, 2617 Pennsylvania Avenue, S.E. Wash.,D.C. 20020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not entar tha mode of dying, such as cardiec or respiretory errest, shock, or heert failure. List only one causa on aech line.

		Approximete Interval Between Onset end Deeth
Immediata Ceuse (Final diseese or condition resulting in deeth) e.	SEVERE ASPIRATION PNEUMONNIA	4 DAYS
Due to (or es a consequence of): b.	ANOXIC ENCEPHALOPATHY	15 DAYS
Sequentially list conditions, if eny, leeding to immedieta cause. Enter Underlying Ceuse (Diseese or injury thet initieted events rasulting in deeth) Lest. Due to (or es e consequence of): c.	ACUTE LEFT CEREBROVASCULAR ACCIDENT	15 DAYS
Due to (or es e consequence of): d.	ACUTE MYOCARDIAL INFARCTION	15 DAYS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were eutopsy findings eveileble prior to compiation of cause of deeth? 1☐ Yas 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No
26. Plece of Deeth (Check only one): Hospitel: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)
27. Mennef of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
26e. Pleca of injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) end menner stated.
29b. Signatura and title of certifiar: M.D.
29c. License number: D43772
29d. Dete signed (Month, Dey, Year): 12/23/97
30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): RASAD ABU M.D. 7501 SURRATTS ROAD, SUITE 208B, CLINTON MD 20735

State Registrar

31. Dete filed (Month, Day, Year): DEC 29 1997
32. Registrar's Signeture: Julie Henderson Archuleta

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41179

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Myrtle Nichols

2. Date of Death Month Day Year: December 25, 1997

3. Time of Death: 7:50 am

4e. Facility Name (If not institution, give street and number): Sacred Heart Home

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-48-7576

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 97 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 26, 1900

9. Birthplace (State or Foreign Country): Alabama

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5805 Queens Chapel Road

10f. Zip Code: 20782

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Owner

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): John Edward Ptomey

18. Mother's Name (First, Middle, Maiden Surname): Cornelia Davis

19a. Informant's Name/Relationship (Type, Print): Bert Nichols - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3504 Oliver Street, Hyattsville, Maryland 20782

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): G. Washington Cemetery

Date: 12/29/97

20c. Location - City or Town, State: Adelphi, Maryland

21. Signature of Funeral Service Licensee: Dorothy Jean Duty

22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia, aspiration — 2 days

Due to (or as a consequence of):

b. Senile dementia — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Peter M. Schissler

29c. License number: 022780

29d. Date signed (Month, Day, Year): December 26, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Peter M. Schissler, M.D. 7500 Greenway Center Drive #430, Greenbelt, MD 20770

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41180

Physician /Medical Examiner

1. Decedent's Nema *(First, Middla, Last)*: Gloria Jean Norris

2. Data of Death — Month: Dec — Day: 21, — Year: 1997

3. Tima of Death: 1;03 AM

4a. Facility Nama *(If not institution, giva street and number)*: Doctors Community Hospital

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 213-40-5379

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 56 Yrs.

If Under 1 Yaar — Months: — Days:

If Undar 24 Hrs. — Hours: — Min.:

8. Data of Birth *(Month, Day, Year)*: Oct 5,1941

9. Birthplace *(State or Foreign Country)*: Wash., D. C.

Usual Residance of Dacedant

10a. Stata: MD.

10b. County: Prince George

10c. City, Town or Location: New Carrollton

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 6128 Lamont Drive

10f. Zip Coda: 20874

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Marriad 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Give Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedant's Education *(Specify only highast grada complatad)*: Elementary/Secondary (0-12): 11 — Collega (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: Telemarketing

16b. Kind of Businass/Industry: Cable Co.

17. Fathar's Nama *(First, Middla, Last)*: Ralph O. Neal

18. Mothar's Nama *(First, Middla, Maidan Sumama)*: Thelma Stewart

19a. Informant's Name/Ralationship *(Type, Print)*: George Norris-Husband

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 6128 Lamont Dr.,New Carrollton, MD.20874

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nema of cematary, cramatory or othar placa)*: N. Virginia Crem.

Data: 12-24

20c. Location - City or Town, Stata: Arl., Va.

21. Signatura of Funaral Sarvica Licansaa: Phillip Bell

22. Nama and Address of Facility: Funeral Services Assoc. 1425 Maryland Ave.,N. E. Wash., D. C.

Physician /Medical Examiner

23a. Part1. Entar the disaasa, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximate Intarval Between Onset and Death

Immadiata Causa (Final disaasa or condition resulting in daath)

a. SMALL Cell Ca, Lung — Months

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated avants rasulting in daath) Last

b. — Dua to (or as a consequance of):

c. — Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying cause givan in Part I.: ASCVD- MI, DIABetes type2, Pancreatitis

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yas 2☐ No

24b. Ware autopsy findings available prior to complation of cause of daath? 1☐ Yes 2☒ No

25. Was case referred to medical examinar? 1☐ Yas 2☒ No

28. Place of Deeth *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☐ Nursing Home 5☐ Rasidence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not ba determinad

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Streat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Cartifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examinar:** On the basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of cartifiar: W. Plumo MD

29c. License number: D32261

29d. Data signed *(Month, Day, Yaar)*: 12-31-97

30. Nama and addrass of parson who completed causa of daath (Item 23a) (Type, Print): Richard J. Fellman MD 9500 Annapolis Rd, Lanham MD 20706

State Registrar

31. Data filed *(Month, Day, Yaar)*: DEC 31 1997

32. Ragistrar's Signatura: Patricia Henderson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41181

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES S. NICKERSON

2. Date of Death Month Dey Year: DEC. 25 1997

3. Time of Death: 8:45 am

4a. Facility Neme *(If not institution, give street and number)*: BUILDING 20 APT. 7 SILOPANNA ROAD

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 216-68-8131

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 39 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: MAY 25 1958

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ANNAPOLIS

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: BUILDING 20 APT. 7 SILOPANNA ROAD

10f. Zip Code: 21403

10g. Citizen of What Country?: US

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorcad

12. Wes Decadent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: 1979-83

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 8th; College (1-4or 5+): 0

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: JANITORIAL

16b. Kind of Business/Industry: HYATT REALTOR

17. Fether's Name *(First, Middle, Last)*: DANIEL NICKERSON

18. Mother's Neme *(First, Middle, Maiden Surneme)*: CARRIE THOMAS

19a. Informent's Name/Relationship *(Type, Print)*: TINA BELT (SISTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 5753 HAZELWOOD CIRCLE APT. A BALTIMORE, MD. 21206

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other placa)*: MARYLAND VETERAN CEMETERY

Date: 1/2/98

20c. Location - Clty or Town, Stete: CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee: ▶ Harry B. Reese

22. Neme end Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Widely metastatic Ca Colon — 2 yea

Due to (or es e consequenca of):

Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last

b. Due to (or as a consequenca of):

c. Due to (or as a consequenca of):

d.

Part Ii. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☐ No

26. Place of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the ceuse(s) and manner steted. 2☐ **Medical Examiner:** On the basis of examination and/or Investigetion, in my opinion, death occurred et the time, dete end piece, and due to the cause(s) and manner steted.

29b. Signature and title of certifier: Michael J. LaPenta M.D.

29c. License number: D 21438

29d. Date signed *(Month, Day, Year)*: Dec 30 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL J. LAPENTA M.D. 160 N RIDGELY AVE STE 120 ANNAPOLIS MD 21401

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41182

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carlyle Nelson

2. Date of Death Month / Day / Year: Dec 22 1997

3. Time of Death: 8:25 A.M.

4a. Facility Name *(If not institution, give street and number)*: Golden Oaks Nursing Home

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-14-3365

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 6, 1912

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Virginia

10b. County: Loudoun

10c. City, Town or Location: Middleburg

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 38454 Limekiln Road

10f. Zip Code: 20118

10g. Citizen of What Country?: United States of America

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance

16b. Kind of Business/Industry: United States of America Fed. Govt.

17. Father's Name *(First, Middle, Last)*: Abraham Nelson

18. Mother's Name *(First, Middle, Maiden Surname)*: Fannie Grooms

19a. Informant's Name/Relationship *(Type, Print)*: Power of John Ellison /Friend & Attorney

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4505 Clermont Drive, N.W. #307, Washington, DC 20011

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Olive Cemetery | Date: December 29,1997

20c. Location - City or Town, State: Lincoln, Virginia

21. Signature of Funeral Service Licensee: #M00690 Howard A Causey

22. Name and Address of Facility: Royston Funeral Home Middleburg, Virginia

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Renal Failure — Due to (or as a consequence of): — 4 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. — Due to (or as a consequence of):

c. — Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Thrombocytopenia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gary W. Jones MD

29c. License number: D30111

29d. Date signed *(Month, Day, Year)*: Dec 22 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Gary W. Jones MD 11305 Pitsea Drive Beltsville Md 20705-1757

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41183

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Nemide Ozgun

2. Date of Death Month / Day / Year: Dec. 27, 1997

3. Time of Death: 9:25pm

4a. Facility Name *(If not institution, give street and number)*: Augsburg Lutheran Home

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 216-94-7862

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: March 1 1910

9. Birthplace *(State or Foreign Country)*: Turkey

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6811 Campfield Road

10f. Zip Code: 21207

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

16b. Kind of Business/Industry: domestic

17. Father's Name *(First, Middle, Last)*: Arif Gultay

18. Mother's Name *(First, Middle, Maiden Surname)*: Saniye

19a. Informant's Name/Relationship *(Type, Print)*: Dr. Suha Ozgun (son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9745 Gingerwood Dr. Ellicott City, Md. 21042

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Crest Lawn Memorial | Date: 12-31-97

20c. Location - City or Town, State: Marriottsville, Md

21. Signature of Funeral Service Licensee: ▶ Paige Haight Herbert

22. Name and Address of Facility: Haight Funeral Home & Chapel, P.O. Box 195 Sykesville, Md. 21784

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Alzheimers — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: tracheomalacia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D37573

29d. Date signed *(Month, Day, Year)*: Dec 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeff Zibell MD 7220 Park Heights Ave. Baltimore MD 21208

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997

32. Registrar's Signature: Julia Gardner Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41184

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Grace Ossing

2. Date of Death Month: 12 Day: 22 Year: 1997

3. Time of Death: 4.30PM

4a. Facility Name (If not institution, give street and number): 110 Smithwood Avenue

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-39-7200

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 4 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov 5 1993

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Md.

10b. County: Baltimore

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 110 Smithwood Avenue

10f. Zip Code: 21228

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): none

16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): Daniel Albert Ossing

18. Mother's Name (First, Middle, Maiden Surname): Megan Grace Murphy

19a. Informant's Name/Relationship (Type, Print): Mr. & Mrs. Dan Ossing (parents)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 110 Smithwood Ave. Baltimore, Md. 21228

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Crest Lawn Memorial | Date: 12-27-97

20c. Location - City or Town, State: Marriottsville, Md.

21. Signature of Funeral Service Licensee: ▶ Paige Haight Herbert

22. Name and Address of Facility: Haight Funeral Home & Chapel, P.O. Box 195 Sykesville, Md. 21784

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Progressive Brain Tumor.

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ M. Dadash-Zadeh

29c. License number: D32153

29d. Date signed (Month, Day, Year): 12/23/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Mahbouben Dadash-Zadeh Sinai Hospital of Baltimore - Pediatric Oncology 2401 W Belvedere Ave Baltimore, MD 21215

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41185
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ethel M Owens
2. Data of Death Month Day Year: Dec 25, 1997
3. Time of Death: 9:40 A.M.
4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital
4b. City, Town, or Location of Death: Clinton
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-40-2920
6. Sex: 1☐ M 2☒ F X
7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Yaar): Dec. 5, 1907
9. Birthplaca (State or Foreign Country): Washington, D.C.

Usual Residence of Decedant

10a. State: Maryland
10b. County: Charles
10c. City, Town or Location: Indian Head
10d. Insida City Limits: 1☐ Yas 2☒ No X
10e. Street and Number: 4480 Doncaster Drive
10f. Zip Coda: 20640
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Marriad 2☐ Married 3☒ Widowed X 4☐ Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Ricen, atc.): 1☐ Yas 2☒ No Specify:
14. Race - Amarican Indian, Black, Whita, atc. Specify: White

15. Dacedant's Education (Specify only highast grada complatad): Elamentary/Secondary (0-12): 5 | College (1-4or 5+):
16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Homemaker
16b. Kind of Businass/Industry: Own Home

17. Fathar's Nama (First, Middla, Last): Gerado Tassa
18. Mothar's Nama (First, Middla, Maidan Surnama): Congetta Ressa

19a. Informant's Name/Raletionship (Type, Print): Albert Andrade/Son-in-law
19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 4480 Doncaster Dr. Indian Head, Md. 20640

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Nama of cematary, crematory or othar place): Resurrection Cemetery | Date: 12/29/97
20c. Location - City or Town, Stata: Clinton, Md.

21. Signature of Funeral Service Licensee: George P Kalas
22. Nama and Address of Facility: George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

CR

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that ceused the daath. Do not anter tha moda of dying, such as cerdiac or respiratory errest, shock, or haart failure. List only ona ceusa on aach lina.

Approximate Interval Between Onsat and Death

Immadiata Cause (Finel disaasa or condition resulting in daath)
a. SEPTICEMIA

Dua to (or as a consequence of):
b. PNEUMONIA AND PLEURAL EFFUSION

Sequentially list conditions, if any, laading to immediata ceusa. Entar Underlying Ceusa (Disaasa or Injury that initieted avants resulting in daath) Last

Dua to (or as a consequanca of):
c. CONGESTIVE HEART FAICURE

Dua to (or as a consequanca of):
d. RENAL FAICURE

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying ceusa givan in Part I.
HYPERTENSIVE CARDIOVASCULAR DISEASE
BLEEDING GASTRIC ULCER
RESPIRATORY FAICURE

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No
24b. Ware autopsy findings availabla prior to complation of causa of death? 1☐ Yas 2☐ No

25. Was cesa rafarrad to madical examinar? 1☐ Yas 2☑ No

26. Placa of Death (Check only ona)
Hospital: 1☑ Inpatiant 2☐ ER/Outpatiant 3☐ DOA
Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determined

28a. Data of Injury (Month, Day Yaar) | 28b. Tima of Injury | 28c. Injury at Work? 1☐ Yas 2☐ No | 28d. Describe how injury occurred

28e. Placa of Injury - At home, farm, straat, factory, office building, atc. (Specify) | 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifiar (Check only one): 1☑ **Certifying Physician:** To the bast of my knowledga, daath occurred at the time, data and placa, and due to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and placa, and due to the cause(s) and mannar atated.

29b. Signatura and title of certifiar: Danilo G. Lee MD
29c. Licansa number: D15789
29d. Date signad (Month, Day, Yaar): 12/26/97

30. Name and addrass of parson who complatad causa of daath (Item 23e) (Type, Print): DANILO G. LEE MD
7700 OLD BRANCH AVENUE CLINTON, MD 20735

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

State Registrar

31. Data filed (Month, Day, Yaar): DEC 29 1997
32. Registrar's Signatura: Julia Hudson Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41186

AMEND# 10G cms 12/23/97 AACO HEALTH

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louisa Elizabeth Orndorff
2. Date of Death Month Day Year: December 20, 1997
3. Time of Death: 11:00 pm
4a. Facility Name (If not institution, give street and number): 1330 Bay Head Road
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-42-5942
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug 17, 1904
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1330 Bay Head Road
10f. Zip Code: 21401
10g. Citizen of What Country? ~~White~~ USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Charles W. Clayton
18. Mother's Name (First, Middle, Maiden Surname): Mary L. Holbrook

19a. Informant's Name/Relationship (Type, Print): Mary Hammond/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 402 Audrey Avenue, Baltimore, MD 21225

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Druid Ridge Cemetery | Date: Dec 24 1997
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Cerebrovascular Disease — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D.
29c. License number: 027938
29d. Date signed (Month, Day, Year): 12/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mayer Gorbaty M.D. 795 Aquahart Rd. Glen Burnie, MD 21061

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): DEC 28 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 5, per F.H. G-755 1/27/98 reb

Certificate of Death

Reg. No. 97 41187

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Dorothy Young Oldham
2. Date of Death Month Day Year: December 18 1997
3. Time of Death: 2AM
4a. Facility Name (If not institution, give street and number): 1754 Meadow Hill Drive
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: ~~316-05-2599~~ 293-09-8811
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov 14 1919
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1754 Meadow Hill Drive
10f. Zip Code: 21401
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Datas:
13. Was Dacedant of Hispanic Origin? (Spacify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decedent's Educetion (Specify only highest grade completad)
Elementary/Secondery (0-12): 12
College (1-4or 5+): 5
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Civil Service Worker
16b. Kind of Business/Industry: Social Security Administration

17. Father's Name (First, Middla, Last): William J. Young
18. Mother's Name (First, Middle, Meiden Sumame): Kathleen Irwin

19a. Informent's Name/Ralationship (Type, Print): Morris M. Oldham (Husband)
19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1754 Meadow Hill Drive Annapolis, Maryland 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Hillcrest Memorial Cemetery Data: 12/20/97
20c. Location - City or Town, State: Annapolis, Maryland

21. Signature of Funeral Service licensee: Donald A. Taylor
22. Nama and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one causa on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. STROKE — 1 week

Due to (or as a consequence of):

Sequantially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Lest
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part fl. **Othar significant conditions** contributing to death but not resulting in tha undarlying causa given in Part f.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cesa referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Peter R. Verkouw MD
29c. Licansa number: D 11653
29d. Data signed (Month, Day, Year): Dec 19, 1997
30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Peter R. VERKOUW 2003 Med. Pkway, Annapolis MD, 21401

State Registrar

31. Date filed (Month, Dey, Yaar): DEC 23 1997
32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41188

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Viola Williamson Patterson
2. Date of Death Month Day Year: December 26, 1997
3. Time of Death: 8:10 AM
4a. Facility Name *(If not institution, give street and number)*: Mediplex- Montgomery Village
4b. City, Town, or Location of Death: Gaithersburg
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-54-5938
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 87 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: September 29, 1910
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residance of Decedent

10a. State: MD
10b. County: MONT
10c. City, Town or Location: WHEATON
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 3501 KAYSON STREET
10f. Zip Code: 20906
10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 12 YEARS
College (1-4or 5+): NONE
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life, even if retired)*: ANALYST
16b. Kind of Business/Industry: FEDERAL EMPLOYEE
United States Government

17. Father's Name *(First, Middle, Last)*: ELEAZA WILLIAMSON
18. Mother's Name *(First, Middle, Malden Surname)*: ALBERTA WHITE

19a. Informant's Name/Relationship *(Type, Print)*: CLIFFORD L. PATTERSON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3501 KAYSON ST., WHEATON MD., 20906

5

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: LINCOLN MEMORIAL CEMETERY
Data: 12/30/97
20c. Location - City or Town, State: SUITLAND, MD.

21. Signature of Funeral Service Licensee: Juan Smith
22. Name and Address of Facility: John T. Rhines and Company Funeral Home 3030 12th Street, N.E., Washington, D.C.

Physician /Medical Examiner

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*
Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28b. Time of Injury: M
28c. Injury at Work? 1☐Yes 2☒No
28d. Describe how injury occurred
28e. Date of Injury *(Month, Day, Year)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gabriel A Berrebi
29c. License number: B30692
29d. Date signed *(Month, Day, Year)*: DECEMBER 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GABRIEL A. BERREBI, MD., 15200 SHADY GROVE RD, ROCKVILLE, MD.

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997
32. Registrar's Signature: John Smith Parker

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41189

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FREDDIE VERNON PRICE

2. Deta of Death — Month: DECEMBER Dey: 27, Yaer: 1997

3. Tima of Death: 12:48 P.M.

4a. Facility Name (If not institution, give street and number): MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death: CAMP SPRINGS

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 579-54-3776

6. Sax: 1☒M 2☐F

7. Age (In yrs. last birthdey): 57 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Dey, Yaer): Dec. 15, 1940

9. Birthplace (Stata or Foreign Country): Fredericksburg, VA

Usual Residence of Decedant

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Clinton

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 5328 West Boniwood Turn

10f. Zip Coda: 20735

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Nevar Married 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedant Evar in U.S. Armed Forces? 1☐Yas 2☒No If Yas, Giva Yaar or Datas:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- It Yas, specify Cuban, Maxican, Puerto Rican, atc.) 1☐Yas 2☒No Specify:

14. Race - American Indien, Bleck, Whita, atc. Specify: Black

15. Decadant's Education (Specify only highast grada completed): Elemantary/Secondery (0-12): 12 — Collega (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired): Retired U.S. Postal Employee

16b. Kind of Business/Industry: Government

17. Fathar's Nama (First, Middle, Last): John Robert Price

18. Mothar's Nama (First, Middla, Maiden Surneme): Florine Lamar

19a. Informant's Name/Raiationship (Type, Print): Willie James - Brother-in-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 3613 Tyrol Drive, Landover, Maryland 20785

20a. Mathod ot Disposition: 1☒Burial 2☐Cramation 3☐Removal from State 4☐Donation 5☐Othar (Specify)

20b. Place of Disposition (Nama of cematary, crematory or othar place): Harmony Memorial Park — Date: 1/2/98

20c. Location - City or Town, Steta: Landover, MD

21. Signeture of Funarel Service Licensee: John T. Stewart III

22. Nama end Address of Facility: STEWART FUNERAL HOME, Inc. 4001 Benning Road, N. E.,Washington, D. C.

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.**

NAME: FREDERICK VERNOR PRICE

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda ot dying, such as cardiac or respiratory arrest, shock, or haart tailura. List only ona causa on aach line.

		Approximata Interval Between Onsat and Death
Immediate Cause (Final disaasa or condition rasulting in daath) a.	CHRONIC RENAL FAILURE	UNKNOWN
Dua to (or as a consequence of):		
Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Ceuse (Disease or Injury that Initiated events rasulting in death) Lest b.	CYCLOPHOSPHAMIDE, METHOTREXATE AND FLUOROURACIL	UNKNOWN
Dua to (or as a consequance of):		
c.		
Due to (or as a consequance of):		
d.		

Part II. **Other significant conditions** contributing to death but not rasulting in the undarlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy parformed? 1☐Yas 2☒No

24b. Wara autopsy findings available prior to completion of causa of death? 1☐Yas 2☒No

25. Was case ratarred to medical examinar? 1☒Yes 2☐No

28. Place of Death (Check only ona) — Hospital: 1☐Inpatiant 2☒ER/Outpatiant 3☐DOA — Other: 4☐Nursing Home 5☐Rasidence 8☐Othar (Specify)

27. Mennar of Death: 1☒Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Panding Invastigation 6☐Could not be datarmined

28a. Data of Injury (Month, Day Yaar)

28b. Tima ot Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurred

28e. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best ot my knowledga, daath occurred at tha tima, data and place, and due to the ceuse(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination end/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha causa(s) and mannar stated.

29b. Signeture and title of certifier:

29c. Licansa number: G77968-CA

29d. Date signed (Month, Day, Yaar): DECEMBER 27, 1997

30. Name end address of parson who complated causa ot death (Item 23e) (Type, Print): JOHN K. WALL, CAPT, USAF, MC — 89 MDG/1050 W PERIMETER RD SUITE C1-7 ANDREWS AIR FORCE BASE, MD 20762-6600

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Data filed (Month, Day, Yaar): DEC 31 1997

32. Registrar's Signatura: Julia Strickson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41190

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Teddy Lee Price

2. Date of Death (Month, Day, Year): December 30, 1997

3. Time of Death: 2009

4a. Facility Name *(If not institution, give street and number)*: Harford Memorial Hospital

4b. City, Town, or Location of Death: Havre de Grace

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 215-32-7654

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 28, 1936

9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Aberdeen

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 320 North East Road

10f. Zip Code: 21001

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7; College (1-4 or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer

16b. Kind of Business/Industry: Plasterer

17. Father's Name *(First, Middle, Last)*: Victor Price

18. Mother's Name *(First, Middle, Maiden Surname)*: Rosetta Walls

19a. Informant's Name/Relationship *(Type, Print)*: Alma E. Price (Spouse)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 320 North East Road, Aberdeen, Maryland 21001

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bel Air Memorial Gardens

Date: 1/2/98

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Kenneth B. Cargo

22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

2009

12-30-97

Teddy Lee Price

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — 1 DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Andrew Nowakowski MD

29c. License number: D08096

29d. Data signed *(Month, Day, Year)*: DECEMBER 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANDREW NOWAKOWSKI MD, 125 N MAIN ST. BEL AIR, MD 21014

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 31 1997

32. Registrar's Signature: Julie Sheridan-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41191

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Charles Walter Pierce

2. Dete of Death (Month, Dey, Yeer): December 23, 1997

3. Time of Death: 3:54 P.M.

4e. Fecility Neme (If not institution, give street and number): 907 Philadelphia Road

4b. City, Town, or Location of Deeth: Joppa

4c. County of Death: Harford

Funeral Director

5. Sociel Security Number: 216-12-0250

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. lest birthdey): 74 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): March 5, 1923

9. Birthplece (Stete or Foreign Country): Maryland

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 907 Philadelphia Road

10f. Zip Code: 21085

10g. Citizen of Whet Country?: USA

11. Merital Stetus: 1☐ Never Merried 2☒ Merried 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No. If Yes, Give Yeer or Detes: 1943-45

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1☐ Yes 2☒ No Specify:

14. Rece - Americen Indien, Bleck, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grede completed): Elementery/Secondery (0-12): 8 | College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Warehouseman

16b. Kind of Business/Industry: U.S. Government

17. Fether's Neme (First, Middle, Last): Walter Howard Pierce

18. Mother's Neme (First, Middle, Meiden Surneme): Ernestena Louise Kammerer

19a. Informent's Neme/Reletionship (Type, Print): Edith R. Pierce/ Wife

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 907 Philadelphia RD, Joppa, MD 21085

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Trinity Lutheren Cemetery

Dete: 12-27-97

20c. Location - City or Town, Stete: Joppa, Maryland

21. Signeture of Funerel Service Licensee: Stephen A Hough

22. Neme end Address of Feciliity: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in death): e. PANCREATIC CANCER — 2 YEARS

Due to (or as e consequence of):

Sequentielly list conditions, if eny, leeding to immediete ceuse. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Lest:

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. **Did tobecco uee contribute to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicel examiner? 1☐ Yes 2☑ No

26. Piece of Deeth (Check only one): Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, and due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete and piece, end due to the ceuse(s) end menner steted.

29b. Signeture and title of certifier: John P. Edwards MD

29c. License number: D 31775

29d. Dete signed (Month, Dey, Yeer): DECEMBER 23, 1997

30. Neme and edress of person who completed ceuse of deeth (Item 23a) (Type, Print): JOHN P. EDWARDS, MD 2712 BELAIR ROAD AUSTIN, MARYLAND 21047

To the Hospital or Attending Physician: The law requires that the deeth certificete be executed within 24 hours after death.

To the Funeral Director: After this certificete hes been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 30 1997

32. Registrar's Signeture: Judi Drucker-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41192

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Margaret Elizabeth Pumphrey
2. Date of Death — Month: December; Day: 18; Year: 1997
3. Time of Death: 2:27 AM
4a. Facility Name *(If not institution, give street end number)*: Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 577-16-4440
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: May 18, 1914
9. Birthplace *(State or Foreign Country)*: Washington, D.C.

Usual Residence of Decadant

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Edgewater
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street and Number: 3680 First Ave.
10f. Zip Coda: 21037
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Married 2☐ Marriad 3☒ Widowed 4☐ Divorced
12. Was Decedant Evar in U.S. Armad Forcas? 1☐ Yes 2☒ No — If Yes, Give Yaar or Datas:
13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxicen, Puarto Rican, etc.): 1☐ Yas 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Dacedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Key Punch Operator
16b. Kind of Business/Industry: IRS

17. Fethar's Nama *(First, Middle, Last)*: Unknown Wilson
18. Mothar's Nama *(First, Middle, Maiden Surneme)*: Elizabeth Zeigler

19a. Informant's Name/Ralationship *(Type, Print)*: Ralph E. Pumphrey, Jr./Son
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 5903 Cable Ave. Camp Springs, Md. 21037

20a. Mathod of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Metropolitan Crematory — Data: 12/20/97
20c. Location - City or Town, Stata: Alexandria,Va.

21. Signetura of Funaral Service Licensaa: George P. Kalas
22. Nama and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater,Md.21037

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha daath. Do not antar tha moda of dying, such as cerdiac or respiretory errest, shock, or haart failura. List only ona causa on aach lina.

		Approximate Intarval Batwaan Onset and Death
Immediate Ceusa (Final disaasa or condition resulting in daath) a.	Acute anterior MI	Immediate
Due to (or es e consequance of): b.	Generalized aTherosclerosis	Yrs
Saquentially list conditions, if any, laading to immadiata ceusa. Entar Underlying Ceusa (Diseasa or Injury that initiated avants rasulting in daath) Last — Dua to (or as a consaquanca of): c.		
Dua to (or as a consaquanca of): d.		

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.: Upper GI bleed 2° Mallory-Weiss; Anemia; Normal-Pressure hydrocephalus

23b. Did tobacco use contribute to the cauae of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No
24b. Were autopsy findings available prior to complation of ceuse of deeth? 1☐ Yas 2☐ No

25. Was cesa rafarrad to medical axeminer? 1☐ Yas 2☒ No
26. Piece of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA; Othar: 4☐ Nursing Home 5☐ Residence 6☐ Othar *(Specify)*
27. Mannar of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be detarmined
28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascriba how injury occurred
28a. Place of Injury - At home, farm, straat, factory, office building, atc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowladga, daath occurrad at tha tima, data and place, and dua to tha cause(s) and mennar as stated. 2☐ **Medical Examinar:** On tha basis of examinetion and/or Invastigation, in my opinion, daath occurred at the tima, date and place, and due to the ceuse(s) and mannar statad.

29b. Signatura and title of certifiar: Joseph N. Friend M.D
29c. Licensa number: D17965
29d. Data signed *(Month, Dey, Year)*: 12/18/97

30. Nama and address of person who completed ceuse of deeth (Item 23e) (Type, Print): Joseph N. Friend 205 Ridgely Ave Annapolis, md.

State Registrar

31. Date filed *(Month, Day, Yeer)*: DEC 22 1997
32. Registrer's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41193

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FLORENCE M. PRINCE

2. Date of Death: Month Dec, Day 18, Year 1997

3. Time of Death: 5:50 PM.

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-24-6310

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.

8. Date of Birth (Month, Day, Year): MAY 21, 1928

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: PASADENA

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1945 HILLTOP ROAD

10f. Zip Code: 21122

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4or 5+): N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR

16b. Kind of Business/Industry: MAIF

17. Father's Name (First, Middle, Last): LOUIS YOUNGER

18. Mother's Name (First, Middle, Maiden Surname): CAROLINE ROSE BOBER

19a. Informant's Name/Relationship (Type, Print): DEBORAH H. HARTSOCK (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 202 MARYLAND AVENUE, CUMBERLAND, MD. 21502

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): CHESAPEAKE CREMATORY, INC

Date: 12/19/97

20c. Location - City or Town, State: BELTSVILLE, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Anoxic Encephalopathy — 24 hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Sherif Elassal, MD.

29c. License number: Be 5333 3644

29d. Date signed (Month, Day, Year): Dec, 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHERIF Elassal North Arundel Hospital 301 Hospital Drive Glen Burnie 21061

State Registrar

31. Date filed (Month, Day, Year): DEC 23 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41194

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CATHERINE RADCLIFFE PAYNE

2. Date of Death: Month 12 Day 29 Year 1997

3. Time of Death: 0800 AM

4a. Facility Name *(If not institution, give street and number)*: Anne Arundel General Hospital

4b. City, Town, or Location of Death: Annapolis, Maryland

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 221 60 8420

8. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth *(Month, Day, Year)*: Oct/9/1913

9. Birthplace *(State or Foreign Country)*: Delaware

Usual Residence of Decedent

10e. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 526 Ferry Point Road

10f. Zip Code: 21403

10g. Citizen of What Country?: United Kingdom

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Frederick R. Jackson

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth Winchester

19e. Informant's Name/Relationship *(Type, Print)*: Oliver Payne (son)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 526 Ferry Point Rd, Annapolis MD 21403

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: 12/30

20c. Location - City or Town, State: Alexandria VA

21. Signature of Funeral Service Licensee: ▶ Michelle Wagoner

22. Name and Address of Facility: Advent Funeral & Cremation Services Annapolis MD 21401

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Carcinoma of the Colon — 4 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

b. ___

Due to (or as a consequence of):

c. ___

Due to (or as a consequence of):

d. ___

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Robert Scott Eden, M.D.

29c. License number: D30701

29d. Date signed *(Month, Day, Year)*: 12/29/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ROBERT SCOTT EDEN, M.D., 1410 Forest Dr., Annapolis, Md 21403

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41195

NAME KNOWN TO PHYSICIAN: FRANCIS DENNIS QUIRK

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Francis Dennis Quirk
2. Date of Death Month / Dey / Year: December 23 1997
3. Time of Death: 5:25 PM
4a. Facility Neme *(If not institution, give street and number)*: VA Maryland Health Care System
4b. City, Town, or Location of Deeth: Perry Point
4c. County of Deeth: Cecil

Funeral Director

5. Social Security Number: 217-03-4432
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Mar. 11, 1917
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. Stete: Maryland
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1☒Yes 2☐ No
10e. Street end Number: 1307 Ontario Street
10f. Zip Code: 21078
10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorcad
12. Was Decedent Ever in U.S. Armed Forces?: 1☒ Yes 2☐ No If Yes, Give Year or Detes: 1942-45
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 — College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Accountant/Cashier
16b. Kind of Business/Industry: U.S. Government

17. Fether's Neme *(First, Middle, Last)*: James Quirk
18. Mother's Neme *(First, Middle, Meiden Surname)*: Agnus Gleason

19a. Informant's Name/Relationship *(Type, Print)*: Louise R. Quirk (Spouse)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1307 Ontario St., Havre de Grace, Maryland 21078

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Plece of Disposition *(Name of cemetery, crematory or other place)*: St. Paul's Lutheran Cem.
Date: 12/27/97
20c. Location - City or Town, State: Aberdeen, Maryland

21. Signature of Funeral Servica Licansee: ▶ Kenneth B. Cargo
22. Name and Address of Fecility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Cause (Final diseese or condition resulting in deeth)
a. Congestive Heart Failure — 2 Months

Due to (or es a consequence of):
b. Ischemic Cardiomyopathy — 10 Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Arteriosclerotic Cardiovascular Disease — 10 Years

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cerebrovascular Accident with Residual

23b. Did tobacco use contribute to the cause of death?: 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?: 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death?: 1☐ Yes 2☐ No

25. Wes case referred to medical examiner?: 1☐ Yes 2☒ No
26. Plece of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, etreet, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) end manner as stated. 2☐ **Medicat Examiner:** On the basis of examination and/or Investigetion, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Angelo Lucco
29c. License number: D30951
29d. Dete signed *(Month, Day, Year)*: 12/23/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): ANGELO LUCCO, M.D., VA Maryland Health Care System, Perry Point, MD 21902

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997
32. Registrar's Signature: ▶ Julia Strickler Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41196

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EVELYN PEARL REUSCHEL

2. Date of Death Month / Day / Year: DECEMBER 30, 1997

3. Time of Death: 7:25 P.M.

4a. Facility Name *(If not institution, give street and number)*: 611 OLDTOWN ROAD

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 214-07-6920

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: APRIL 20,1917

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: ALLEGANY

10c. City, Town or Location: CUMBERLAND

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 611 OLDTOWN ROAD

10f. Zip Code: 21502

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind of Business/Industry: HOME

17. Father's Name *(First, Middle, Last)*: CLEALAND W. CLINE

18. Mother's Name *(First, Middle, Maiden Surname)*: NELLIE E. NORTHCRAFT

19a. Informant's Name/Relationship *(Type, Print)*: SANDRA HERRING/DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 701 GLENMORE STREET, CUMBERLAND, MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SUNSET MEMORIAL PARK

Date: 1/3/98

20c. Location - City or Town, State: CUMBERLAND, MD

21. Signature of Funeral Service Licensee: Henry N. Upchurch

22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — less than 1 hour

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE — GREATER THAN 5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Terry E. Williams M.D.

29c. License number: D16041

29d. Date signed *(Month, Day, Year)*: JANUARY 2,1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TERRY E. WILLIAMS, M.D. - 500 MEMORIAL AVE., CUMBERLAND, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998

32. Registrar's Signature: John [illegible]

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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NHS

DHMH 16 Rev 6/95

97-2484-001
CIP
RONALD LEE RICHARDS
Items:23a part I,27 per MEO G-756 2/3/98 dh

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41197

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ronald Lee Richards

2. Date of Death — Month: DECEMBER Day: 31, Year: 1997

3. Time of Death: 3:11 PM

4a. Facility Name *(If not institution, give street and number)*: SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 217-42-7017

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 53 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 18-Apr-44

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Allegany

10c. City, Town or Location: Frostburg

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 191 S. Water Street

10f. Zip Code: 21532-

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1964-1967

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 4 — College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Filtration Plant Operator

16b. Kind of Business/Industry: City Water Plant

17. Father's Name *(First, Middle, Last)*: Thomas J. Richards, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Maudella Williams

19a. Informant's Name/Relationship *(Type, Print)*: Leann M. Richards Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 191 South Water Street Frostburg Maryland 21532-

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Frostburg Memorial Park

Date: 04-Jan-98

20c. Location - City or Town, State: Frostburg, Maryland

21. Signature of Funeral Service Licensee: John R. Durst

22. Name and Address of Facility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CHLORINE GAS EXPOSURE COMPLICATING HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? ☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural ☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: 12/31/97

28b. Time of Injury: 2:10 P M

28c. Injury at Work? 1☒ Yes 2☐ No

28d. Describe how injury occurred: Exposed to chlorine gas while working on gas cylinder

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: building

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Water Treatment Plant Frostburg, MD

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Dennis J. Chute MD

29c. License number: O.C.M.E.

29d. Date signed *(Month, Day, Year)*: JANUARY 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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MS

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998

32. Registrar's Signature

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41198

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Catherine Richardson

2. Date of Death Month: 12 Day: 24 Year: 1997

3. Time of Death: 11:45 AM

4a. Facility Name *(If not institution, give street and number)*: Medpointe Nursing Home

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 220-03-1500

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 94 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 09/09/1903

9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: Havre de Grace

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 417 North Stokes St

10f. Zip Code: 21078

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Remus Winfield Testerman

18. Mother's Name *(First, Middle, Maiden Surname)*: Louise Barker

19a. Informant's Name/Relationship *(Type, Print)*: Virginia Matthews- Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 419 Stokes St. Havre de Grace, MD 21078

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Bel Air Memorial Gardens

Date: 12/29/97

20c. Location - City or Town, State: Bel Air, MD

21. Signature of Funeral Service Licensee: Madelyn Mitchell Smith

22. Name and Address of Facility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington St. Havre de Grace, MD

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic lung cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hypertension
Anemia

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Hisup Sim MD

29c. License number: 046412

29d. Date signed *(Month, Day, Year)*

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Hisup Sim MD 5 S. Union Ave Havre de Grace MD 21078

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41199

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Howard Neil Ritchey

2. Date of Death (Month, Day, Year): DECEMBER 22 1997

3. Time of Death: 0505

4a. Facility Name (If not institution, give street and number): Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 544-36-3057

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 30, 1935

9. Birthplace (State or Foreign Country): Iowa

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1110 Moores Mill Road

10f. Zip Code: 21014

10g. Citizen of What Country: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4or 5+): 5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Civil Engineer

16b. Kind of Business/Industry: US Government

17. Father's Name (First, Middle, Last): Roscoe (NMN) Ritchey

18. Mother's Name (First, Middle, Maiden Surname): Viola (NMN) Rickel

19a. Informant's Name/Relationship (Type, Print): Jacqueline Ritchey/ Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1110 Moores Mill Road, Bel Air, MD 21014

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Jarrettsville Cemetery

Date: 12-27-97

20c. Location - City or Town, State: Jarrettsville, Maryland

21. Signature of Funeral Service Licensee: Howard K McComas

22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury RD, Abingdon, Maryland 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. PANCREATIC CANCER — 3 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

LIVER METASTASES

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [✓] No

26. Place of Death (Check only one): Hospital: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [✓] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John P. Edwards MD

29c. License number: D31775

29d. Date signed (Month, Day, Year): DECEMBER 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN P. EDWARDS MD 2112 BELAIR ROAD FALLSTON, MARYLAND 21047

State Registrar

31. Date filed (Month, Day, Year): DEC 23 1997

32. Registrar's Signature: Julia Dunbar Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

RITCHEY/ HOWARD
Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

14

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41200

CARL Everett Royal

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Carl Everett Royal	Dec 23rd 1997	18:50 hrs

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ER Harford Memorial Hospital	Havre De Grace	Harford

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
235-30-8328	1☒M 2☐F	71 Yrs.			May 26, 1926	West Virginia

Usual Residence of Decadant

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Harford	Aberdeen	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
808 Adams Avenue	21001	U.S.A.

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WW II	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
11	0	Truck Driver	Lubricant Company

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William E. Royal	Mattie O. Hall

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Geraldine Smith (Sister in law)	92 Sharon Street, Rising Sun, Maryland 21911

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Harford Memorial Gardens	12/27/97	Aberdeen, Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Kenneth B. Cargo	Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Acute Coronary Artery Disease	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. ASCVD	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Hypertension

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined	NA	NA M	1☐Yes 2☒No	NA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
NA	NA

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5+1

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ DME	OCME	Dec 24th 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

G.S.Prabhu M.D. 218 Fulford Ave Bel Air MD. 21014 410-879-6564

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 29 1997	▶

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41201

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Roy Francis Railer

2. Date of Death Month / Day / Year: December 25, 1997

3. Time of Death: 6:00 P.M.

4a. Facility Name *(If not institution, give street and number)*: 101 Oak Street

4b. City, Town, or Location of Death: Edgewood

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 219-14-7120

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 26, 1924

9. Birthplace *(State or Foreign Country)*: Michigan

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Edgewood

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 101 Oak Street

10f. Zip Code: 21040

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No

If Yes, Give Year or Dates: 1942 1966

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12):

College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Military

16b. Kind of Business/Industry: U. S. Government

17. Father's Name *(First, Middle, Last)*: Bert (UK) Railer

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna (UK) Duckworth

19a. Informant's Name/Relationship *(Type, Print)*: Mrs. Rosalie M. Railer - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 101 Oak Street, Edgewood, MD 21040

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Bel Air Memorial Gardens

Date: 12/30/97

20c. Location - City or Town, State: Bel Air, MD

21. Signature of Funeral Service Licensee: Howard K. McComas

22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

CAJ

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYELODYSPLASTIC SYNDROME — 4 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mike Ryan

29c. License number: D38409

29d. Data signed *(Month, Day, Year)*: 12/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): William Simpson 4940 Easton Ave Baltimore, Md 21224

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997

32. Registrar's Signature: Julia Davidson-Randall

12+1

Medical Certification: To Be Completed by Physician/Medical Examiner

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41202

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Kaden Reese

2. Date of Death Month: December Day: 27 Year: 1997

3. Time of Death: 0022

4a. Facility Name (If not institution, give street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: none

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday) Yrs.: If Under 1 Year Months: Days: If Under 24 Hrs. Hours: 30 Min.: 22

8. Date of Birth (Month, Day, Year): December 25 97

9. Birthplace (State or Foreign Country): M D

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Crofton

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1689 Walleye Drive

10f. Zip Code: 21114

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): Collage (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): none

16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): Matthew Jacob Reese

18. Mother's Name (First, Middle, Maiden Surname): Jennifer Williams Reese

19a. Informant's Name/Relationship (Type, Print): Matthew Reese / Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1689 Walleye Drive Crofton, MD 21114

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Crematory

Date: 12/28/97

20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Brian J. Shaw

22. Name and Address of Facility: John M. Taylor Funeral Home 147 Duke of Gloucester Annapolis, MD 21401

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Extreme Prematurity — 30 hrs

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequance of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one) Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: X Milton W. Werthmann Jr MD

29c. License number: D11497

29d. Date signed (Month, Day, Year): December 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): X Milton W. Werthmann JR 2001 Medical Parkway, Annapolis MD 21401

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41203

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Moritz Ritterbusch

2. Date of Death Month Day Year: December 21, 1997

3. Time of Death: 2:07 AM

4a. Facility Name *(If not institution, give street and number)*: 689 Red Cedar Road

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-10-1839

6. Sex: 1☐M 2☐F XX

7. Age *(In yrs. last birthday)*: 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 30, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Md.

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐Yes 2☐No X

10e. Street and Number: 689 Red Cedar Road

10f. Zip Code: 21401

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed X 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: '41-'45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No X *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: General Foreman

16b. Kind of Business/Industry: Gas & Electric Utilities

17. Father's Name *(First, Middle, Last)*: John Ritterbusch

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Rimback

19a. Informant's Name/Relationship *(Type, Print)*: Gloria R. Rund (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 511 Grandin Ave. Severna Park, Md. 21146

20a. Method of Disposition: 1☒Burial X 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St. Margarets Cemetery

Date: 12-24-97

20c. Location - City or Town, State: Annapolis, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause *on* each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory paralysis — 12h

Due to (or as a consequence of):

b. T6 Cord lesion — 3 mo

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Metastatic Adenocarcinoma — 1 yr

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D21438

29d. Date signed *(Month, Day, Year)*: Dec 22 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MICHAEL J. LaPENTA MD 600 RIDGELY AVE STE 12W ANNAPOLIS MD 21401

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 23 1997

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41204

Physician / Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth P Rutter
2. Date of Death (Month, Day, Year): December 27, 1997
3. Time of Death: 3:05 AM
4a. Facility Name (If not institution, give street and number): Annapolis Nursing and Rehab
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 214-12-9743
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): January 28, 1908
9. Birthplace (State or Foreign Country): Delaware

Usual Residence of Decedent

10a. State: Maryland
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1502 Masonetta Way
10f. Zip Code: 21401
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Amarican Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Key Punch Operator
16b. Kind of Business/Industry: Income Tax

17. Father's Name (First, Middle, Last): Amos Pierson
18. Mother's Name (First, Middle, Maiden Surname): Annie Hanson

19a. Informant's Name/Relationship (Type, Print): Lynn Williams (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1502 Masonetta Way Annapolis, MD 21401

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Fort Lincoln Crematory | Date: Dec.29,1997
20c. Location - City or Town, Stata: Brentwood, MAryland

21. Signature of Funeral Service Licensee: B. J. Ch...
22. Nama end Address of Facility: John M. Taylor Funeral Home, Inc 147 Duke of Gloucester St. Annapolis, MD 21401

Physician / Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Renal Failure — 10 days
Due to (or as a consequence of):
b. Insulin Dependent Diabetes Mellitus — 20 years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.: Denied Ins

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Othar: 4☒ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, atreet, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: R.L. Hardiman, MD
29c. License number: D05192
29d. Data signed (Month, Day, Year): 12/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard I. Hardman, MD 1833 A Forest Dr, Annapolis, Md. 21401

State Registrar

31. Date filed (Month, Dey, Year): DEC 31 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41205

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EARLE ROYER STALEY

2. Date of Death Month: 12 Day: 29 Year: 97

3. Time of Death: 11:29 PM

4a. Facility Name *(If not institution, give street and number)*: Carroll County General Hospital

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 217-01-8069

6. Sex: 1 X M 2 ☐ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 6, 1914

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Taneytown

10d. Inside City Limits: 1 X Yes 2 ☐ No

10e. Street and Number: 233 E. Baltimore St.

10f. Zip Code: 21787

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:

14. Race - American Indian, Black, White, etc. Specify: Caucasian

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Salesman

16b. Kind of Business/Industry: Shoes

17. Father's Name *(First, Middle, Last)*: John Clayton Staley

18. Mother's Name *(First, Middle, Maiden Surname)*: Minnie Royer

19a. Informant's Name/Relationship *(Type, Print)*: Wayne Staley/Nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 233 E. Baltimore St., Taneytown, MD 21787

20a. Method of Disposition: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Trinity Lutheran Cem.

Date: 1/3/98

20c. Location - City or Town, State: Taneytown, Maryland

21. Signature of Funeral Service Licensee: John M. Skiles MO0534

22. Name and Address of Facility: Skiles Funeral Home, 136 E. Baltimore St., Taneytown, MD 21787

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finat disease or condition resulting in deeth)

a. G-I. Bleeding — 24hrs

Due to (or as a consequenca of):

b. Coagulopathy — 24hrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequenca of):

c. Acute arterial occlusion. — 24hrs

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cardiomyopathy.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) end menner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D39502

29d. Date signed *(Month, Day, Year)*: 12/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 5430 S. Hosam 412, Malcolm drive Westminster MD 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 02 1998

32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41206

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Dorothy Bell Snyder

2. Date of Death — Month: December Day: 24 Year: 1997

3. Time of Death: 6:00AM

4a. Facility Name *(If not institution, give street and number)*: Glade Valley Nursing & Rehab. Center

4b. City, Town, or Location of Death: Walkersville

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 220-28-8194

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 78 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Sept. 3, 1919

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Taneytown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4135 Walnut Grove Rd.

10f. Zip Code: 21787

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 7

College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: John Toms

18. Mother's Name *(First, Middle, Maiden Surname)*: Daisy Eyler

19a. Informant's Name/Relationship *(Type, Print)*: Nancy S. Arnold/ daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13402 Rabbit Run Terrace Union Bridge, MD 21791

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Haugh's Cemetery

Date: 12/27/97

20c. Location - City or Town, State: Ladiesburg, MD

21. Signature of Funeral Service Licensee: Catharine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home 6 E. Broadway Union Bridge, MD 21791

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CVA — 1 WK

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert L. Kaufmann

29c. License number: D13971

29d. Date signed *(Month, Day, Year)*: 12/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Robert L. Kaufmann 300 W. 9th St. Frederick, MD 21701

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997

32. Registrar's Signature: Julie Strider Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

97 41207

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ONEIDA MAE SKILES			2. DATE OF DEATH (Month, Day, Year): 12 / 25 / 97	3. TIME OF DEATH: 8 pm
4. SOCIAL SECURITY NUMBER: 217-05-7852	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11/29/19	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 314 E. Baltimore St.		9b. CITY, TOWN OR LOCATION OF DEATH: Taneytown		9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Taneytown	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 314 E. Baltimore St.		10f. ZIP CODE: 21787	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Merwyn Charles Fuss		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah Viola Marker	
19a. INFORMANT'S NAME (Type/Print): Diana F. Skiles/Daughter		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 314 E. Baltimore St., Taneytown, MD 21787	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Trinity Lutheran Cem. DATE: 12/29	20c. LOCATION — City or Town, State: Taneytown, MD 21787	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John M. Skiles M00534		22. NAME AND ADDRESS OF FACILITY: Skiles Funeral Home 136. E. Baltimore St., Taneytown, MD 21787	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. DESSEMINATED CANCER OF THE PANCREAS	2 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Wm. R. Linthicum (M.D.)	31317	▶ 12/25/97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WILLIAM R. LINTHICUM, M.D. ONE KING'S DRIVE, TANEYTOWN, MD 21787

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 30 1997	Julia Strickler-Randall

DHMH-15 Rev 1/89

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41208

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DOROTHY SMITH
2. Date of Death: Month December Day 27 Year 1997
3. Time of Death: 12:55 PM
4a. Facility Name (If not institution, give street and number): Fairhaven Health Care Center
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 152-10-7683
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 101 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr 23 1896
9. Birthplace (State or Foreign Country): New Jersey

Usual Residence of Decedent

10a. State: Md
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 7200 Third Avenue
10f. Zip Code: 21784
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): registered nurse
16b. Kind of Business/Industry: health care

17. Father's Name (First, Middle, Last): Leonard Clark Haskell
18. Mother's Name (First, Middle, Maiden Surname): Mary Collins Brown

19a. Informant's Name/Relationship (Type, Print): Marion S. Anderson (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 200 Brightdale Rd. Timonium, Md. 21093

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Carroll Cremation Serv.
Date: 12-29-97
20c. Location - City or Town, State: Hampstead, Md.

21. Signature of Funeral Service Licensee: ▶ Paige Haight Herbert
22. Name and Address of Facility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Degenerative dementia	2 years
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Ellis Mez MD
29c. License number: D22220
29d. Date signed (Month, Day, Year): December 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ellis Mez 1645 Liberty Road Eldersburg, MD. 21784

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997
32. Registrar's Signature: ▶ Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97 41209

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELLA. MAE STEVE			2. DATE OF DEATH (Month, Day, Year): 12-19-97	3. TIME OF DEATH: 1.47-PM
4. SOCIAL SECURITY NUMBER: 220.72.9555	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4-6-12.	8. BIRTHPLACE (State or Foreign Country): LOUISIANA
9a. FACILITY NAME (If not institution, give street and number): SPRINGFIELD HOSP.		9b. CITY, TOWN OR LOCATION OF DEATH: Sykesville	9c. COUNTY OF DEATH: CARROLL COUNTY	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: CARROLL	10c. CITY, TOWN OR LOCATION: Sykesville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1 MAIN Street		10f. ZIP CODE: 21784	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 8+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWORK	16b. KIND OF BUSINESS/INDUSTRY: Domestic

17. FATHER'S NAME (First, Middle, Last): Louis Steve	18. MOTHER'S NAME (First, Middle, Maiden Surname): Cecile Mayeaux
19a. INFORMANT'S NAME (Type/Print): Springfield Central Records	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1 Main St. Sykesville, Md. 21784

20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SPRINGFIELD CEMETERY 12/22/97	20c. LOCATION — City or Town, State: SYKESVILLE, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry W. Haight	22. NAME AND ADDRESS OF FACILITY: Haight Funeral Home P.O.Box 195 Sykesville, Md. 21784

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pulmonary Edema	
	DUE TO (OR AS A CONSEQUENCE OF): CHF. Atrial Fibrillation	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Shakera Khan. MD.	29c. LICENSE NUMBER: D36291.	29d. DATE SIGNED (Month, Day, Year): ▶ 12-19-97.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SHAKERA. KHAN. SPRINGFIELD HOSP. CTR. SYKESVILLE MD 21784

31. DATE FILED (Month, Day, Year): DEC 29 1997	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41210

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: Gerald Richard Springborn
2. Dete of Death Month Day Yeer: December 23, 1997
3. Tima of Death: 11:30 pm
4a. Facility Nema *(If not institution, give street and number)*: Magnolia Gardens Nursing Home
4b. City, Town, or Location of Deeth: Lanham
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-09-7948
6. Sax: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 82 Yrs.
If Under 1 Yeer: Months / Days
If Undar 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Oct. 12, 1915
9. Birthplaca *(Stata or Foraign Country)*: Ohio

Usual Rasidance of Dacadant

10a. Stata: Maryland
10b. County: Prince George's
10c. City, Town or Location: Hyattsville
10d. Insida City Limits: 1☒ Yes 2☐ No
10e. Street and Numbar: 6109 40th Avenue
10f. Zip Coda: 20782
10g. Citizan of Whet Country?: U.S.A.

11. Marital Status: 1☐ Navar Marriad 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Dacedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puerto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Rece - American indian, Bleck, Whita, atc. *Specify:* White

15. Decedant's Education *(Specify only highast grada compiatad)*: Elamentary/Secondary (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Plate Maker
16b. Kind of Businass/Industry: Federal Government

17. Fether's Nema *(First, Middle, Last)*: John Springborn
18. Mothar's Nama *(First, Middle, Maidan Sumama)*: Mary McCamic

19a. Informant's Name/Ralationship *(Type, Print)*: Gladys J. Springborn - Wife
19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 6109 40th Avenue, Hyattsville, Maryland 20782

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Place of Disposition *(Nama of cematary, cramatory or othar place)*: St. John's Episopal Cemetery
Data: 12/27/97
20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Timothy Dean Dunn
22. Nama and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused the death. Do not antar the moda of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one cause on each lina.

Approximate Intarval Between Onset and Death

Immediata Causa (Finel disaasa or condition resulting in daath)
e. Pneumonia

Due to (or as a consequance of):
b. Cerebrovascular Accident — 2weeks

Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Ceusa (Disaasa or Injury that initiated evants resulting in deeth) Last

Dua to (or as a consequance of):
c.

Dua to (or es e consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to complation of cause of death? 1☐ Yas 2☐ No

25. Was casa rafarred to medical examiner? 1☐ Yas 2☑ No

28. Place of Deeth *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Othar: 4☑ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Dete of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, etc. *(Spacify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☑ **Certifying Physician:** To tha bast of my knowledga, deeth occurred at tha tima, data and place, end dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination end/or investigation, in my opinion, deeth occurred at tha tima, data and place, and due to the causa(s) and mennar stated.

29b. Signatura and title of certifiar: George C. Hajjar, Jr. M.D.
29c. License number: 039550
29d. Dete signed *(Month, Day, Year)*: 12/24/97

30. Nema end address of person who complated causa of death (Item 23a) (Type, Print): George C. Hajjar, Jr. M.D. 4850 Forbes Blvd. Lanham, md. 20706

State Registrar

31. Date filed *(Month, Day, Yaar)*: DEC 29 1997
32. Registrar's Signatura: Julie Atwater Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

12

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41211

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anna M. Stacherski

2. Data of Death Month Day Yaar: December 25, 1997

3. Tima of Deeth: 11:50 am

4a. Facility Nama *(If not institution, giva street and number)*: Sacred Heart Home

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Numbar: 193-09-6843

6. Sex: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 79 Yrs.

If Under 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: May 29, 1918

9. Birthplaca *(Stata or Foreign Country)*: Pennsylvania

Usual Residence of Decedant

10a. Stata: Virginia

10b. County: Falls Church

10c. City, Town or Location: Great Falls

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 1024 Cup Leaf Holly Court

10f. Zip Coda: 22066

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowad 4☐ Divorcad

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Bieck, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12): 12 / Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use ratirad)*: Cashier

16b. Kind of Business/Industry: Grocery Store

17. Fathar's Name *(First, Middle, Last)*: Stanley Cygnarowicz

18. Mothar's Nama *(First, Middla, Maidan Surname)*: (Unavailable)

19a. Informant's Name/Ralationship *(Type, Print)*: Judith Lachowicz - Daughter

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 1024 Cup Leaf Holly Court, Great Falls, VA 22066

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: St. Stanislaus Cemetery

Data: 12/29/97

20c. Location - City or Town, State: Pittsburg, PA

21. Signature of Funaral Service Licansaa: J. B Gasch

22. Nama and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

CR

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrast, shock, or haart feilura. List only one causa on aach lina.

Approximate Intarval Batween Onsat and Death

Immadiata Causa (Final diseasa or condition resulting in death)

a. pneumonia, aspiration — days

Dua to (or as a consequanca of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or injury that initiated avants resulting in daath) Last

b. senile dementia — years

Dua to (or as a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha undarlying causa givan in Part I.: hypertension and diabetes mellitus

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to compliation of cause of death? 1☐ Yas 2☐ No

25. Was cesa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Othar: 4☒ Nursing Homa 5☐ Rasidence 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determinad

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28e. Placa of Injury - At homa, farm, straat, factory, office building, etc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurrad at the time, data and place, and due to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurrad at tha time, dete and place, and due to tha cause(s) and mannar stated.

29b. Signatura and titla of certifiar: Peter M. Schissler

29c. License number: D22780

29d. Data signed *(Month, Day, Yaar)*: December 26, 1997

30. Nama and address of parson who completed cause of death (Itam 23a) (Type, Print): Peter M. Schissler, M.D. 7500 Greenway Center Drive #430, Greenbelt, MD 20770

State Registrar

31. Data filed *(Month, Day, Yaar)*: DEC 29 1997

32. Ragistrar's Signatura: Julia Henderson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requiras that the daath certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(10)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41212

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Norval Floyd Stanley
2. Date of Death Month / Day / Year: Dec 25 1997
3. Time of Death: 0644
4a. Facility Name *(If not institution, give street and number)*: Sacred Heart Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 217-30-1949
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 65 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 5, 1932
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Allegany
10c. City, Town or Location: La Vale
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 10112 Stanley Lane NW
10f. Zip Code: 21502
10g. Citizan of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yas, Give Year or Dates: 1956-1957
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - Americen indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)* — Elamentary/Secondary (0-12): 12 — College (1-4or 5+): 5+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Chemical Engineer
16b. Kind of Business/Industry: Engineering
17. Father's Name *(First, Middle, Last)*: Clarence K. Stanley
18. Mother's Name *(First, Middle, Maidan Surname)*: Clara Frey
19a. Informant's Name/Relationship *(Type, Print)*: Mary Jane Stanley, Wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 10112 Stanley Lane NW, LaVale, MD 21502
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cramatory or other place)*: Philos Cemetery — Date: Dec 27, 1997
20c. Location - City or Town, State: Westernport, MD
21. Signature of Funeral Service Licensee: Douglas L. Hafer
22. Name and Address of Facility: Hafer Chapel of the Hills Mortuary, 1302 National Hwy, LaVale, MD 21502

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not entar the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failura. List only one cause on each line. — Approximata Interval Between Onset and Death

Immediata Cause (Final disease or condition resulting in death)
a. CARDIAC ARREST - VENTRICULAR FIBRILLATION — ONE HOUR
Due to (or as a consequence of):
b. PRIMARY CARDIAC ARRHYTHMIA - ACUTE — TWO HOURS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CHRONIC CARDIAC ARRHYTHMIA - ATRIAL FIBRILLATION — TWO YEARS
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
BIVENTRICULAR CARDIOMYOPATHY
CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of daath? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatiant 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or investigation, in my opinion, daath occurred at tha time, date and place, and due to the cause(s) and manner steted.

29b. Signeture and title of certifier
29c. License number: D33417 (Md)
29d. Dete aigned *(Month, Day, Year)*: 12/26/97 (December 26, 1997)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): JAMES R. MOEN, M.D. 1068 NATIONAL HIGHWAY LAVALE, MARYLAND 21502

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997
32. Registrar's Signatura

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by tha attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

11 +1 VA 12 mlf

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41213

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JACQUELINE D. SABY
2. Date of Death: Month: December; Day: 26; Year: 1997
3. Time of Death: 1346
4a. Facility Name (If not Institution, give street and number): University of Maryland Medical Systems 22 South Greene Street
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: City

Funeral Director

5. Social Security Number: 218-34-1485
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 58 Yrs.
If Under 1 Year: Months; Days
If Under 24 Hrs.: Hours; Min.
8. Date of Birth (Month, Day, Year): Apr. 26, 1939
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Aberdeen
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 46 Green Avenue
10f. Zip Code: 21001
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Secretary
16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): Argyll Day
18. Mother's Name (First, Middle, Maiden Surname): Edith Wallen

19a. Informant's Name/Relationship (Type, Print): Richard H. Saby (Spouse)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 46 Green Avenue, Aberdeen, Maryland 21001

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harford Memorial Gardens
Date: 12/30/97
20c. Location - City or Town, State: Aberdeen, Maryland

21. Signature of Funeral Service Licensee: ▶ Kenneth B. Cargo
22. Name and Address of Facility: Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. Ruptured Superior Vena Cava

Due to (or as a consequence of):
b. Attempted Intravascular Stent Placement

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c. Superior Vena Caval Syndrome

Due to (or as a consequence of):
d. Non Small Cell Lung Cancer

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Arnel Mendoza Tagle MD
29c. License number: AU4176435 AT 3093
29d. Date signed (Month, Day, Year): December 26, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Arnel Mendoza Tagle MD University of Maryland Medical Systems 22 South Greene Street Baltimore Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997
32. Registrar's Signature: ▶ Judi Dresher-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41214

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Rufus Spencer
2. Date of Death Month / Day / Year: 12 / 29 / 1997
3. Time of Death: 20:08
4a. Facility Name *(If not institution, give street and number)*: Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-10-9732
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 06/30/1913
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 563 Otsego Street
10f. Zip Code: 21078
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Clerk
16b. Kind of Business/Industry: Electronics
17. Father's Name *(First, Middle, Last)*: Harry Garfield Spencer
18. Mother's Name *(First, Middle, Maiden Surname)*: Erma Davis
19a. Informant's Name/Reletionship *(Type, Print)*: Anna Marie K. Spencer- Wife
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 563 Otsego St. Havre de Grace, MD 21078
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Angel Hill Cemetery
Date: 1/3/98
20c. Location - City or Town, State: Havre de Grace, MD
21. Signature of Funeral Service Licensee: George M. Hampton Jr.
22. Name end Address of Facility: Mitchell-Smith Funeral Home, P.A. 123 S. Washington St. Havre de Grace, MD

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode ot dying, such es cardiac or respiratory arrest, shock, or heart teilure. List only one cause on eech line. — Approximate Interval Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in deeth)
e. Possible Acute Myocardial Infarction — ? minutes

Due to (or es e consequence of):
b. Arteriosclerotic Coronary artery disease — years

Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or Injury thet Initiated events resulting in deeth) Lest

Due to (or es e consequenca of):
c. Hypertension. — Years

Due to (or es e consequenca of):
d. Aortic stenosis

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [✓] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [✓] No

26. Piece of Deeth *(Check only one)*: Hospital: 1 [✓] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [✓] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece ot Injury - At home, tarm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) end manner as stated. 2 [ ] **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) end menner stated.

29b. Signature end title of certifier: F. Kou M.D
29c. License number: D48271
29d. Date signed *(Month, Day, Year)*: 12/30/97

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): FAHED KOU M.D 319 S. Union Ave, Havre de grace, MD 21078

State Registrar

31. Dete filed *(Month, Dey, Year)*: DEC 31 1997
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,
William Rufus Spencer
12-29-1997
Dec 2008
6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41215

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William Lee Stratton Sr.

2. Date of Death (Month, Day, Year): December 21, 1997

3. Time of Death: 10:00 AM

4a. Facility Name *(If not institution, give street and number)*: 307 Green Way Drive

4b. City, Town, or Location of Death: Bel Air

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 195-24-4967

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 19, 1931

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 307 Green Way Drive

10f. Zip Code: 21014

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1952-54

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Operations Manager

16b. Kind of Business/Industry: Petroleum

17. Father's Name *(First, Middle, Last)*: Virgil Ray Stratton

18. Mother's Name *(First, Middle, Maiden Surname)*: Ellen H. Wight

19a. Informant's Name/Relationship *(Type, Print)*: William Lee Stratton Jr./Son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5 Kenlock Place, Atlanta, Ga. 30305

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Bel Air Memorial Gardens

Date: 12-27-97

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Howard K. McComas III

22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury RD, Abingdon, Maryland 21009

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☒ **Yes** 2☐ No 3☐ **Probably** 4☐ **Unknown**

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul Colaco, MD

29c. License number: D30929

29d. Date signed *(Month, Day, Year)*: 12/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PAUL COLACO, MD 6569 N. Charles ST. BALTIMORE MD 21204

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 23 1997

32. Registrar's Signature: [illegible] Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41216

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Martin Robert Smith

2. Date of Death Month: December Day: 28 Yaar: 1997

3. Time of Death: 1743

4a. Facility Neme (If not institution, give street end number): Union Hospital of Cecil County

4b. City, Town, or Location of Deeth: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 215-40-1522

6. Sax: 1☒M 2☐F

7. Age (In yrs. lest birthday): 54 Yrs.

If Undar 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): Sept. 27, 1943

9. Birthplece (Stete or Foreign Country): Pennsylvania

Usual Residenca of Decedent

10a. State: Marylan

10b. County: Cecil

10c. City, Town or Location: Childs

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 99 Childs Road

10f. Zip Code: 21916

10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yaar or Dates: 1961-65

13. Wes Dacedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, atc.): 1☐Yes 2☒No Specify:

14. Raca - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): College (1-4or 5+): 5+

16a. Decedent's Usuel Occupation (Give kind of work done duning most of working life. DO NOT use retired): Teacher

16b. Kind of Business/Industry: Education

17. Fsther's Name (First, Middle, Last): Martin J. Smith

18. Mother's Neme (First, Middle, Maiden Surneme): Marian Stephenson

19a. Informent's Neme/Relationship (Type, Print): Tamar K. Smith/Wife

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 99 Childs Road, P.O. Box 77, Childs, MD 21916

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donetion 5☐Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Immaculate Conception Cem. Date: 1/2/98

20c. Location - City or Town, Stata: Cherry Hill, Maryland

21. Signatura of Funerel Sarvica Licensee: Donald L. Hicks

22. Name end Address of Facility: Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921

Physician /Medical Examiner

ETC

23a. Part1. Enter the disaasa, or complications that causad the deeth. Do not enter the moda of dying, such as cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Deeth

Immediate Ceuse (Finat diseese or condition resulting in deeth): e. ACUTE MYOCARDIAL INFARCTION — INSTANTANEOUS

Due to (or es s consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequenca of):

c.

Due to (or es e consequenca of):

d.

Part II. **Other significsnt conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospitel: 1☐Inpatient 2☒ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☐Residenca 6☐Other (Specify)

27. Menner of Deeth: 1☒Neturel 2☐Accident 3☐Suicida 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury (Month, Dey Yeer):

28b. Time of Injury: M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how tnjury occurred

28e. Piece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certtfying Physicien**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner as steted. 2☐ **Medical Examiner**: On the basis of examinetion end/or tnvestigetion, in my opinion, death occurred et the time, dete end piece, snd due to the cause(s) end menner stated.

29b. Signature and title of certifier: S Rahman MD

29c. Licensa number: D 24809

29d. Data signed (Month, Dey, Yeer): 12/30/97

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): EHSANUR RAHMAN SUITE 131, 4745 OGLETOWN-STANTON RD, NEWARK, DE

State Registrar

31. Date filed (Month, Dey, Yeer): DEC 31 1997

32. Registrar's Signature: Lina Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Smith, Martin

81 IVA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41217

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joanne Margaret Smith
2. Data of Death Month Day Year: December 18, 1997
3. Time of Death: 3:50 pm
4a. Facility Name *(If not institution, giva straet and number)*: 357 White Cedar Lane
4b. City, Town, or Location of Death: Severna park
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 232-36-6577
6. Sex: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 68 Yrs.
If Under 1 Yaar: Months / Days
If Undar 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: Mar 12, 1929
9. Birthplece *(State or Foreign Country)*: West Virginia

Usual Residance of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. Clty, Town or Location: Severna Park
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 357 White Cedar Lane
10f. Zip Code: 21146
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - Americen Indian, Black, Whita, atc. *Specify:* White

15. Decedant's Education *(Specify only highest grada completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nurse
16b. Kind of Business/Industry: Pediatric Medicine

17. Fathar's Name *(First, Middle, Last)*: James L. Cain
18. Mother's Name *(First, Middle, Maiden Surname)*: Gertrude Smith

19a. Informant's Name/Relationship *(Type, Print)*: Jack Smith/husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 357 White Cedar Lane, Severna Park, MD 21146

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other placa)*: MD Veterans Cemetery
Date: Dec 23 1997
20c. Location - City or Town, State: Crownsville, MD

21. Signetura of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that causad the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseasa or condition resulting in death): a. Breast Cancer — 6 years

Due to (or es e consequence of):

Sequantially list conditions, if any, leading to Immediata ceuse. Enter Underlying Ceuse (Disease or injury that initiated avents rasulting in death) Last

b. Due to (or es a consequence of):

c. Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uss contributs to the causs of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availablo prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was cese referred to medicel examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatiant 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At homa, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Straet and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: S. Selonich, MD
29c. Licanse numbar: D19838
29d. Data signed *(Month, Day, Year)*: 12/19/97

30. Neme end address of person who completed cause of death (Item 23a) (Type, Print): Stuart E. Selonich 900 Bestgate Rd. Annapolis, MD 21401

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 23 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic avent, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41218

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Richard M. Shaw

2. Date of Death: Month December Day 21 Year 1997

3. Time of Death: 9:10 AM

4a. Facility Name (If not institution, give street and number): Fairhaven Healthcare Center

4b. City, Town, or Location of Death: Sykesville

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 096-28-2729

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 63 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 28, 1934

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Millersville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 890 Oakdale Circle

10f. Zip Code: 21108

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No. If Yes, Give Year or Dates: Korean

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Analyst

16b. Kind of Business/Industry: Healthcare Financing Administration (HCFA)

17. Father's Name (First, Middle, Last): Otto Shaw

18. Mother's Name (First, Middle, Maiden Surname): Teresa Bressler

19a. Informant's Name/Relationship (Type, Print): Gilbert Shaw/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 36 Old Sentinel Hill Road, Derby, Connecticut 06418

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetary, crematory or other place): Metro Crematory

Date: Dec 23 1997

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: James E. Barranco

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis due to Staphylococcus aureus	2 weeks
Due to (or as a consequence of):	b. Decubitus ulcers	6 months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Multiple sclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ellis Mez MD

29c. License number: D22220

29d. Date signed (Month, Day, Year): December 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ellis Mez MD 1645 Liberty Road Eldersburg, MD. 21784

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41219

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGARET M. SELLMAN
2. Date of Death Month Day Yaar: DEC. 22 1997
3. Tima of Deeth: 0219
4a. Facility Nema *(If not institution, give street and numbar)*: ANNE ARUNDEL MEDICAL CENTER
4b. City, Town, or Location of Daath: ANNAPOLIS
4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 219-38-5621
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 70 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth *(Month, Day, Year)*: AUG. 6 1927
9. Birthplace *(State or Foraign Country)*: MARYLAND

Usual Rasidance of Dacedant

10a. Stata: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: ANNAPOLIS
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Street end Numbar: 912 E. ROYAL STREET
10f. Zip Coda: 21401
10g. Citizen of What Country?: US

11. Maritel Status: 1☐ Nevar Marriad 2☒ Married 3☐ Widowad 4☐ Divorcad
12. Wes Dacedant Evar in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:
13. Was Dacedant of Hispanic Origin? (Spacify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indian, Black, White, etc. *Specify:* BLACK

15. Decedant's Education *(Spacify only highest grada complatad)*: Elamantary/Secondary (0-12): 6th; Collega (1-4or 5+): 0
16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: DOMESTIC
16b. Kind of Businass/Industry: OUT OF THE HOME

17. Fether's Nama *(First, Middla, Last)*: WILLIAM H. BROWN
18. Mothar's Nama *(First, Middla, Maidan Surnama)*: GLADYS HALL

19a. Informant's Name/Ralationship *(Type, Print)*: CURTIS SELLMAN (SON)
19b. Mailing Address *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 912 E. ROYAL ST. ANNAPOLIS, MD. 21401

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*
20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: ANNAPOLIS MEM. GARDENS
Date: 12/26/97
20c. Location - City or Town, Stata: ANNAPOLIS, MD.

21. Signature of Funaral Service Licensaa: ▶ Larry S. Reese
22. Nama and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications thet causad tha daath. Do not entar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on each lina.

Approximata Intarval Between Onsat and Deeth

Immediata Causa (Finel disaasa or condition resulting in daath)
a. Cardiopulmonary arrest — 15 minute

Saquantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or Injury that initiated evants resulting in daath) Last
Due to (or as a consequence of):
b. End stage renal disease — years
Due to (or as a consequence of):
c. Hypertension — years
Due to (or as a consequence of):
d. hyperchoLesterolemia — years

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No
24b. Wara autopsy findings availabla prior to completion of cause of daath? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☐ Inpatiant 2☒ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*
28b. Tima of injury M
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28e. Place of Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*
28f. Location *(Streat and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Phyaician**: To tha best of my knowledga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examinar**: On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and due to the causa(s) and mannar stated.

29b. Signature and title of cartifiar: ▶ Norma Chelus MD
29c. Licansa number: D48101
29d. Data signad *(Month, Day, Yaar)*: 12/22/97

30. Nama and addrass of parson who compiatad causa of daath (Itam 23a) (Typa, Print): 1833A Forest Dr. Annapolis MD

State Registrar

31. Date filed *(Month, Day, Yaar)*: DEC 30 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41220

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rose Elizabeth Shipley

2. Date of Death (Month, Day, Year): December 27, 1997

3. Time of Death: 2:30 A.M.

4a. Facility Name (If not institution, give street and number): St. Thomas More Nursing & Rehab Center

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-09-5946

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 23, 1917

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Suitland

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 4697 Homer Avenue, Apt. A

10f. Zip Code: 20746

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Hair Stylist

16b. Kind of Business/Industry: Beauty Salon

17. Father's Name (First, Middle, Last): H. E. Buck

18. Mother's Name (First, Middle, Maiden Surname): Rosie Tucker

19a. Informant's Name/Relationship (Type, Print): James A. Ball/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3075 Tudor Hall Rd. Riva, Maryland 21140

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory | Date: 12/27/97

20c. Location - City or Town, State: Alexandria, Va.

21. Signature of Funeral Service Licensee: ▶ Robert P. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, Md. 21037

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Lung Cancer	6 mos.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Obstructive Pulmonary disease; Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Elwin G. Bustos

29c. License number: D-42936

29d. Date signed (Month, Day, Year): 12/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elwin G. Bustos, M.D. 1328 Southern Ave. Suite 307, Washington, D. C. 20032

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

97-7473-021

WILLIAM TURLEY JR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items:23a part I,27,28a-f per MEO G-755 1/16 /98 dh

Certificate of Death

Reg. No. 97 4 1221

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Curtis Turley, Jr.

2. Date of Death Month Day Year: DECEMBER 25, 1997

3. Time of Death: 10:51A.M.

4a. Facility Name (If not institution, give street and number): 7726 BRIDLE PATH CIRCLE

4b. City, Town, or Location of Death: NEW MARKET

4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 216-82-9300

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 34 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct.31, 1963

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 7726 Bridle Path Circle

10f. Zip Code: 21701

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): truck driver

16b. Kind of Business/Industry: transportation

17. Father's Name (First, Middle, Last): William C. Turley, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Margaret Grauley

19a. Informant's Name/Relationship (Type, Print): Margaret Bennett/ mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7726 Bridle Path Circle Frederick, MD 21701

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Linganore Cemetery

Date: 12/30/97

20c. Location - City or Town, State: Unionville, MD

21. Signature of Funeral Service Licensee: Catherine O. Hartzler

22. Name and Address of Facility: Hartzler Funeral Home 11802 Liberty Rd. Libertytown, MD 21762

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☒ Could not be determined

28a. Date of Injury (Month, Day Year): 12/24/97

28b. Time of injury: unknown M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: unknown

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify): found at residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 7726 Bridle Path Circle, New Market, Md. 21774

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Theodore McGinnis

29c. License number: O.C.M.E.

29d. Date signed (Month, Day, Year): DECEMBER 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): THEODORE McGINNIS 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997

32. Registrar's Signature: Julie Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

WRC
97-1908-510
RICHARD
THOMASSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41222

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
RICHARD LEE THOMASSON	DECEMBER 31, 1997	3:36 PM.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
524 N. CHARLES ST. APT. 611	BALTIMORE	NA

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
200-20-1734	1☒M 2☐F	69 Yrs.			JAN 25 1928	West Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore City	Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
524 North Charles Street Apt 611	21201	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐Never Married 2☐Married 3☐Widowed 4☒Divorced	1☒Yes 2☐No If Yes, Give Year or Dates: WW11	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamentary/Secondary (0-12)	College (1-4or 5+)		
12		Laborer	Aeronautics

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maidan Surname)
Jehu Thomasson	Ida M. Mathew Thomasson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Nancy J. Kuty (Niece)	1713 Temi Drive Waldorf, MD 20601

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cramation 3☐Ramoval from State 4☐Donation 5☐Other (Specify)	Maryland Veterans Cem.		Cheltenham, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ John A. Eberwein M00173	J.H. Eberwein Mortuary 4433 White Pls La White Pls., MD 20695

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Arteriosclerotic Cardiovascular Disease	
	Due to (or as a consequance of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):	
	c. Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
INSPECTION 1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒Yes 2☐No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Panding Investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. Licensa number	29d. Data signed (Month, Day, Year)
▶ Dennis J. Chute M.D.	O.C.M.E.	JAN. 01, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dennis Chute M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 06 1998	Julia Hooker Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41223

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES MONROE TRAWICK JR

2. Date of Death Month Day Year: DECEMBER 29, 1997 FOUND

3. Time of Death: 03:10PM found

4a. Facility Name (If not institution, give street and number): 3402 37TH AVENUE

4b. City, Town, or Location of Death: COLMAR MANOR

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 578-70-8058

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 46 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 10, 1951

9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Colmar Manor

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 3402 37th Avenue

10f. Zip Code: 20722

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed 4☒Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondery (0-12): 7

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sheet Metal Worker

16b. Kind of Business/Industry: Private Industry

17. Father's Name (First, Middle, Last): James Monroe Trawick, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Hall

19a. Informant's Name/Relationship (Type, Print): James M. Trawick, Sr. - Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3402 37th Avenue, Colmar Manor, Maryland 20722

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): George Washington Cemetery

Date: 01/02/98

20c. Location - City or Town, State: Adelphi, Maryland

21. Signature of Funeral Service Licensee: Henry S. Fearl

22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ETHANOL ABUSE

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one)

Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA

Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Mario F. Golle Jr MD

29c. License number: D33954

29d. Date signed (Month, Day, Year): DECEMBER 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F. GOLLE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998

32. Registrar's Signature: Julia Thompson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41224

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Helen Holbrook Tucker

2. Date of Death (Month, Day, Year): December 27, 1997

3. Time of Death: 10:35 p.m.

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-09-0478

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 24, 1917

9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Chevy Chase

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 8700 Jones Mill Road

10f. Zip Code: 20815

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Business Manager

16b. Kind of Business/Industry: Private Industry

17. Father's Name (First, Middle, Last): William Addison Holbrook

18. Mother's Name (First, Middle, Maiden Surname): Zella Pearl Barnett

19a. Informant's Name/Relationship (Type, Print): Irwin William Tucker, Jr. - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8036 Park Lane, Bethesda, Maryland 20814

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Cemetery

Date: 12/30/97

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ Claudette L. Gasch

22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial Infarction — minutes

Due to (or as a consequence of):

b. Adult Respiratory Distress Syndrom — days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Sepsis

Hypotension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death (Check only one) — Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D33357

29d. Date signed (Month, Day, Year): 12/29/97

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Lee Jonathan Musher MD 5530 Wisconsin Ave Chevy Chase MD

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997

32. Registrar's Signature: Julia Thompson-Randall

DHMH 16 Rev 6/95

Help tucker 35pm Dec 27 1997 Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 97 41225

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MICHAEL TURNER
2. Date of Death (Month / Day / Year): December 28 1997
3. Time of Death: 2:20 AM
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 076-48-1562
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 43 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: August 19, 1954
9. Birthplace *(State or Foreign Country)*: New York, N.Y.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Landover
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 7505 Grouse Place
10f. Zip Code: 20785
10g. Citizen of What Country?: U.S.A.

11. Meritel Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Street Vendor
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Leroy Turner
18. Mother's Name *(First, Middle, Maiden Surname)*: Francine Bullock

19a. Informant's Name/Ralationship *(Type, Print)*: Francine Turner/Mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7505 Grouse Place, Landover, Maryland 20785

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory — Date: 12/31 1997
20c. Location - City or Town, State: Beltsville, Maryland

21. Signeture of Funaral Servica Licensea: Nancy A. Percentie
22. Name and Addrass of Facility: J. B. JENKINS FUNERAL HOME, 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or haart failura. List only ona causa on each line.

		Approximata Intervel Between Onset and Death
Immediate Cause (Final diseese or condition resulting in death) a.	PROGRESSIVE MULTIFOCAL LEUKO ENCEPHALOPATHY	2 MONTHS
Dua to (or as a consequanca of): b.	ACQUIRED IMMUNE DEFICIENCY SYNDROME	4 MONTHS
Sequentially list conditions, if eny, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	HIV DISEASE	6 MONTHS
Due to (or as a consequanca of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DISSEMINATED MOLUSCUM

STAPHYLOCOCCUS EPIDERMIDIS SEPSIS

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was casa rafarrad to medical exeminer? 1 [ ] Yes 2 [✓] No

26. Place of Death *(Check only one)*: Hospitel: 1 [✓] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Homa 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [✓] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be datarmined

28a. Data of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Dascribe how injury occurred
28e. Placa of Injury - At homa, farm, straat, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1 [✓] **Certifying Physician**: To tha best of my knowledge, death occurred at the time, date and placa, and due to tha causa(s) and manner as stated. 2 [ ] **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and dua to the cause(s) and menner stated.

29b. Signature and title of cartifier: M.D.
29c. License number: D43772
29d. Date signed *(Month, Day, Year)*: 12/28/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RASAD ABU M.D. 7501 SURRATTS ROAD, SUITE 208, CLINTON MD 20735

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997
32. Registrar's Signature: Julie Henderson Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41226

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JOHN ELLIOTT TERNENT

2. Date of Death (Month, Day, Year): DECEMBER 25 1997

3. Time of Death: 1:33 PM

4a. Facility Name *(If not institution, give street and number)*: MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 215-16-4571

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 76 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: SEPT 10 1921

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: FLINTSTONE

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 13905 BLACK VALLEY ROAD N.E.

10f. Zip Coda: 21530

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Married 2☒ Married 3☐ Widowad 4☐ Divorced

12. Was Dacadant Ever in U,S. Armed Forcas? 1☒ Yes 2☐ No If Yas, Giva Yaar or Datas: WW11

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* WHITE

15. Dacedant's Education *(Specify only highast grade compiatad)*: Elamantary/Secondary (0-12): 8 / Collega (1-4or 5+):

16a. Dacedant's Usual Occupation *(Give kind of work dona during most of working lifa. DO NOT usa ratired)*: KNOX STREET MOTORS

16b. Kind of Businass/Industry: MECHANIC/CO-OWNER

17. Fathar's Nama *(First, Middla, Last)*: WILLIAM J. TERNENT

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: BARBARA McMILLIAN

19a. Informant's Name/Ralationship *(Typa, Print)*: EDNA MARIE TERNENT WIFE

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 13905 BLACK VALLEY ROAD N.E. FLINTSTONE, MD 21530

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: ROCKY GAP VET.CEMETERY

Data: DEC.29 1997

20c. Location - City or Town, Stata: FLINTSTONE MD. RFD

21. Signatura of Funaral Sarvica Licansae: Dale L. Merritt

22. Nama and Addrass of Facility: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Entar tha diseasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximate Intarval Batween Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in daath)

a. EXACERBATION OF CHRONIC BRONCHITIS AND EMPHYSEMA — TWO WEEKS

Dua to (or as a consaquanca of):

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last

b.

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. Othar significant conditions contributing to daath but not rasulting in tha underlying causa givan in Part I.

CONGESTIVE HEART FAILURE

RENAL FAILURE

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to madical examinar? 1☐ Yas 2☒ No

26. Placa of Daath *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarminad

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha bast of my knowladga, daath occurred at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Madical Examinar:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha cause(s) and mannar stated.

29b. Signatura and titla of cartifiar: Mark Sagin

29c. Licansa number: D35481

29d. Data signed *(Month, Day, Year)*: DECEMBER 26th 1997

30. Nama and addrass of parson who complatad cause of daath (Item 23a) (Type, Print): DR. MARK SAGIN MEMORIAL HOSPITAL CUMBERLAND MARYLAND 21502

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Data filad *(Month, Day, Yaar)*: DEC 29 1997

32. Registrar's Signatura: Gabi Strawbridge Barbell

DHMH 16 Rev 6/95

JOHN TERNENT 215-16-4571
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41227

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Nina Mary Tichnell
2. Dete of Death Month Day Year: DECEMBER 24, 1997
3. Time of Death: 1:24 AM
4a. Facility Neme *(If not institution, give street and number)*: Sacred Heart Hospital
4b. City, Town, or Location of Deeth: Cumberland
4c. County of Deeth: Allegany

Funeral Director

5. Social Security Number: 216-18-1141
6. Sex: 1☐M 2☒F
7. Age *(In yrs, last birthday)*: 76 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept 7, 1921
9. Birthplece *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10e. State: MD
10b. County: Allegany
10c. City, Town or Location: Barton
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street end Number: 18709 Temperance Row
10f. Zip Code: 21521
10g. Citizen of Whet Country?: United States

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces?: 1☐Yes 2☒No — If Yes, Give Year or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*
14. Rece - American Indien, Bleck, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): Unknown — College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Home
17. Fether's Neme *(First, Middle, Last)*: George Herbert McVicker
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Marclena Sigler
19e. Informant's Name/Reletionship *(Type, Print)*: Olyn Tichnell/Husband
19b. Melling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 18709 Temperance Row, Barton, Md 21521
20a. Method of Disposition: 1☐Burial 2☒Cremetion 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*
20b. Plece of Disposition *(Name of cemetery, crematory or other place)*: Cumberland Crematory — Dete: 12/24/97
20c. Location - City or Town, State: Cumberland, Md.
21. Signature of Funerel Service Licensee: ▶ J. Wayne Boal
22. Name end Address of Facility: Boal Funeral Home, 111 Church St. Westernport, Md 21562

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert feilure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth)
e. Respiratory failure — few minutes
Due to (or as a consequence of):
b. Congestive heart failure — 60 days
Due to (or es e consequence of):
c. pneumonia — 50 days
Due to (or as a consequence of):
d. Cerebral Infarct — 61 days

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet Initiated events resulting in deeth) Lest

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus insulin dependent
Coronary artery disease
Renal failure

23b. Did tobacco use contribute to the cause of death?: 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was en eutopsy performed?: 1☐Yes 2☒No
24b. Were eutopsy findings evelleble prior to completion of cause of death?: 1☐Yes 2☒No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner?: 1☐Yes 2☒No
26. Plece of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpetient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*
27. Manner of Death: 1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work?: 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) end menner es steted. 2☐**Medicel Examiner:** On the besis of examination end/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end menner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D15463
29d. Dete signed *(Month, Day, Year)*: DECEMBER 24, 1997
30. Name end address of person who completed cause of death (Item 23a) (Type, Print): Shin Kim M.D. 96 Main Street Westernport, MD. 21562.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

6 mlf

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997
32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41228

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: UTELKA EMMA THORPE
2. Date of Death Month / Dey / Yaar: DECEMBER 30 1997
3. Tima of Daath: 9:45PM
4a. Facility Nema *(If not institution, give streat end number)*: CUMBERLAND NURSING HOME
4b. City, Town, or Location of Deeth: CUMBERLAND
4c. County of Deeth: ALLEGANY

Funeral Director

5. Social Security Numbar: 212-24-0909
6. Sax: 1☐ M 2☒ F
7. Aga *(In yrs. last birthday)*: 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: APRIL 5 1905
9. Birthplace *(Stata or Foraign Country)*: W.VA.

Usual Residance of Dacadent

10a. Stata: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: CUMBERLAND
10d. Insida City Limits: 1☒ Yas 2☐ No
10e. Straat and Number: 229 BALTIMORE AVE.
10f. Zip Coda: 21502
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowad 4☐ Divorcad
12. Wes Dacadant Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Give Yaar or Datas:
13. Was Dacadant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1☐ Yes 2☒ No *Specify:*
14. Race - Amaricen Indien, Black, White, etc. *Specify:* WHITE
15. Dacadant's Educetion *(Specify only highast grada complatad)*: Elementery/Secondery (0-12): 10 — Collega (1-4or 5+):
16a. Dacadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: HOUSE KEEPER
16b. Kind of Business/Industry: HOUSE KEEPER
17. Fathar's Nama *(First, Middla, Last)*: WILLIAM A. WILLHIDE
18. Mothar's Nama *(First, Middla, Maidan Surneme)*: JESSIE B. ROBEY
19a. Informant's Name/Ralationship *(Type, Print)*: E. ALLEN THORPE SON
19b. Mailing Addrass *(Straat and Number or Rural Routa Number, City or Town, State, Zip Coda)*: 337 DORN AVE. CUMBERLAND MARYLAND 21502
20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Placa of Disposition *(Nama of cematary, cramatory or othar place)*: QUEENS POINT CEMETERY
Data: JAN 3 1998
20c. Location - City or Town, Stata: KEYSER W.VA.
21. Signature of Funeral Service Licensee: Dale L. Merritt
22. Nama and Addrass of Facility: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that causad tha daath. Do not anter tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach line.

Approximata Intarval Batween Onsat and Death

Immediate Causa (Final disaasa or condition resulting in daath)
a. Acute Cerebro Vaaular Accident — 1day

Dua to (or as a consequance of):

Sequantially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disaasa or injury that initiated avants rasulting in daath) Last
b.
Dua to (or as a consaquance of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditiona** contributing to death but not rasulting in tha undarlying ceuse givan in Part I.: Coronary Artery disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Wara autopsy findings availabla prior to completion of cause of daath? 1☐ Yas 2☐ No

25. Was cese rafarred to medical exeminar? 1☐ Yes 2☒ No

28. Placa of Daath *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA — Othar: 4☒ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Pending invastigation 6☐ Could not be datarmined

28a. Deta of Injury *(Month, Day Yaar)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yas 2☐ No
28d. Dascribe how injury occurred
28a. Place of Injury - At home, ferm, straat, factory, office building, etc. *(Specify)*
28f. Location *(Streat and Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To tha best of my knowladga, deeth occurred at the tima, data and plece, end dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner**: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, deta and place, and dua to the ceuse(s) and mannar statad.

29b. Signature and title of certifiar: [signature]
29c. License number: 033280
29d. Date signed *(Month, Dey, Year)*: Jan 1, 1998

30. Nama and addrass of person who complated causa of daath (Item 23a) (Type, Print): DR. SUNIL K. GUPTA 625 KENT AVE CUMBERLAND MARYLAND 21502

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 0 2 1998
32. Registrar's Signature: [signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2
yes

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41229

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LUELLA KING THOMAS

2. Date of Death — Month: December; Day: 27; Year: 1997

3. Time of Death: 7:59 AM

4a. Facility Name *(If not institution, give street and number)*: Fallston General Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 213-12-2677

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 25, 1917

9. Birthplace *(State or Foreign Country)*: N. Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Bel Air

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2021 Ruffs Mill Road

10f. Zip Code: 21015

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 5; College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work dona duning most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme *(First, Middle, Last)*: Joseph (nmn) King

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Mae (nmn) Billings

19a. Informent's Neme/Reletionship *(Type, Print)*: Walter L. Thomas - Nephew

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 2011 A Ruffs Mill Rd., Bel Air, MD 21015

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Bel Air Memorial Gardens — Dete: 12-31-97

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funerel Service Licensee: Howard K. McComas

22. Neme end Addrass of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

		Approximete Interval Between Onset and Deeth
Immediete Ceuse (Finel diseese or condition resulting in deeth) a.	ACUTE RESPIRATORY FAILURE	1 DAY
Due to (or es a consequence of): b.	CHRONIC OBSTRUCTIVE LUNG DISEASE	
Sequentially list conditions, if eny, leading to immedieta cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last — Due to (or as e consequence of): c.		
Dua to (or es e consequenca of): d.		

Part II. **Other significent conditiona** contributing to deeth but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 8☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Deta of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Phyalcian**: To the bast of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner as steted. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Andrew Nowakowski MD

29c. Licensa number: D0S096

29d. Data signed *(Month, Day, Year)*: DECEMBER 27, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): ANDREW NOWAKOWSKI MD 125 N. MAIN ST BEL AIR MD 21014

State Registrar

31. Dete filed *(Month, Day, Year)*: DEC 30 1997

32. Registrer's Signeture: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Luella King Thomas Lyc

6

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41230

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Donald Eugene Tolley

2. Date of Death: Month December Day 31 Year 1997

3. Time of Death: 3:00PM

4e. Facility Name (If not institution, give street and number): Mallard Bay Nursing Home

4b. City, Town, or Location of Death: Cambridge

4c. County of Death: Dorchester

Funeral Director

5. Social Security Number: 220-12-2057

6. Sex: 1 XX M 2 ☐ F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months ____ Deys ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Dey, Year): Dec 24, 1923

9. Birthplace (State or Foreign Country): Maryland

Usuel Residence of Decedent

10a. State: Maryland

10b. County: Dorchester

10c. City, Town or Location: Cambridge

10d. Inside City Limits: XX Yes 2 ☐ No

10e. Street and Number: 520 Glenburn Avenue

10f. Zip Code: 21613

10g. Citizen of Whet Country?: US

11. Maritel Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 XX Divorcad

12. Was Decedent Ever in U.S. Armed Forces? XX Yes 2 ☐ No — If Yes, Give Yeer or Detes: WW II

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 XX No Specify:

14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 8 College (1-4or 5+):

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Waterman

16b. Kind of Business/Industry: Seafood

17. Father's Name (First, Middle, Last): George Herbert Tolley, Sr.

18. Mother's Name (First, Middle, Maiden Surneme): Mary Simmons

19a. Informant's Name/Relationship (Type, Print): Barbara J. Hochreiner Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 3619 Bonnie Lane Linkwood, Maryland 21835

20a. Method of Disposition: XX Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other place): Md. Veterans Cemetery

Date: 1/5/98

20c. Location - City or Town, State: Hurlock, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Fecility: Thomas Funeral Home, P.A. 700 Locust Street Cambridge, Maryland 21613

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular accident — Approx 2 Weeks

Due to (or as a consequence of):

b. Hypertension — Not Known

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last

Due to (or es e consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation - chronic

Dementia.

23b. **Did tobacco use contribute to the cause of death?** 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 X No

26. Piece of Deeth (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year): 12-31-97

28b. Time of Injury: 3:00 P M

28c. Injury et Work? 1 ☐ Yes 2 X No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 X **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end manner es stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and mariner stated.

29b. Signature and title of certifier: [signature] H Burney

29c. License number: D 47520

29d. Dete signed (Month, Day, Year): 1-2-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HAMID BURNEY, M.D., 10 BURKET ST, Cambridge, MD 21613

State Registrar

31. Dete filed (Month, Dey, Year): JAN 5 1998

32. Registrer's Signeture: Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMEND# 19b cms 12/23/97 AACO HEALTH

Certificate of Death

Reg. No. 97 41231

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Louis Raymond Thomas
2. Date of Death: Month December Day 19th Year 1997
3. Time of Death: 2:55 am
4a. Facility Name (If not institution, give street and number): 15 Mariners Way Unit 3
4b. City, Town, or Location of Death: Stevensville
4c. County of Death: Queen Anne

Funeral Director

5. Social Security Number: 102-30-6354
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 59 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept 5th 1938
9. Birthplace (State or Foreign Country): New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Queen Anne
10c. City, Town or Location: Stevensville
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 15 Mariners Way, Unit 3
10f. Zip Code: 21666
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Teacher
16b. Kind of Business/Industry: Assistant Principal Education

17. Father's Name (First, Middle, Last): Louis Thomas
18. Mother's Name (First, Middle, Maiden Surname): Beatrice Spencer

19a. Informant's Name/Relationship (Type, Print): Lori Thomas/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 536 3rd ~~Street~~ Street, NE, Washington, D.C. 20002

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory
Date: Dec 20 1997
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hepatocellular Carcinoma — 6 months

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Seamus O'Reilly MD PhD
29c. License number: D46515
29d. Date signed (Month, Day, Year): December 19th 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SOReilly Johns Hopkins Oncology Center Baltimore MD 21287

State Registrar

31. Date filed (Month, Day, Year): DEC 23 1997
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41232

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Maxwell Tyler

2. Date of Deeth: Month December Day 16 Year 1997

3. Time of Death: 12 AM

4a. Faciiity Nama (If not institution, giva street and number): Anne Arundel Medical Center

4b. City, Town, or Location of Death: Annapolis

4c. County of Daath: Anne Arundel

Funeral Director

5. Social Security Number: 343-28-1873

6. Sex: 1☐M 2☐F

7. Aga (In yrs. last birthday): 94 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 23 1903

9. Birthplaca (State or Foraign Country): Illinois

Usual Residence of Decedent

10e. Stata: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 84 North Old Mill Road Bottom

10f. Zip Code: 21401

10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Merried 3☒Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yas 2☐No If Yes, Give Yaar or Datas: 1921 1924

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yas 2☒No Specify:

14. Raca - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highast grada completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use ratired): Repairman

16b. Kind of Business/Industry: Harness & Shoe

17. Fether's Name (First, Middla, Last): Newton Tyler

18. Mother's Neme (First, Middla, Maidan Surnama): EugeniaPence

19a. Informant's Name/Relationship (Type, Print): Linda Farrell (Neice)

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda): 2060 Quaker Way #8 Annapolis, Maryland 21401

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Neme of camatary, crematory or othar placa): Ft. Lincoln Crematory Date: 12/18/97

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Servica Licansee: Brian J. Clyne

22. Nama and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Batwaen Onsat end Death

Immediate Ceuse (Final disease or condition resulting in death): a. Lung cancer — 1 year

Due to (or es e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Last:

b. Due to (or as a consequenca of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Pert i.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24a. Was en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings available prior to complation of cause of death? 1☐Yes 2☑No

25. Was case referred to medicai examiner? 1☐Yes 2☒No

26. Piece of Deeth (Check only ona): Hospital: 1☑Inpatiant 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Deeth: 1☑Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Describe how injury occurred

28e. Piaca of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piaca, and due to the cause(s) and manner es stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. Licansa number: D48108

29d. Data signed (Month, Day, Year): 12/16/97

30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print): 900 Bestgate Rd #300, Annapolis, MD 21401 Dr. Proestel

State Registrar

31. Dete filed (Month, Day, Yaer): DEC 23 1997

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 4 1233

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AZEAL VILLATE

2. Date of Death (Month, Day, Year): DECEMBER 25, 1997

3. Time of Death: 12:22 PM

4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 579-36-7694

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Dey, Year): Nov. 1, 1909

9. Birthplace (State or Foreign Country): Caroline Co., VA

Usual Residence ot Decedent

10a. State: District of Columbia

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 5906 Southern Avenue, S. E.

10f. Zip Code: 20019

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pesonnel Clerk (Retired)

16b. Kind of Business/Industry: GOV.

17. Father's Name (First, Middle, Last): Napoleon Coleman

18. Mother's Name (First, Middla, Meiden Surname): Lillian Wright

19a. Intormant's Name/Raletionship (Type, Print): Joan Randall - Daughter

19b. Mailing Addrass (Streat and Number or Rural Route Number, City or Town, Stata, Zip Code): 5906 Southern Avenue, S. E.,Washington, D.C. 20019

20a. Method ot Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Lincoln Memorial Cemetery

Data: 1/3/98

20c. Location - City or Town, State: Suitland, MD

21. Signatura of Funeral Service Licensee: John T. Stewart III

22. Name and Address of Facility: STEWART FUNERAL HOME, Inc. 4001 Benning Road, N. E.,Washington, D. C.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart tailure. List only one cause on each line.

Approximata Interval Batween Onset and Death

Immediate Cause (Final disease or condition resulting in daath)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Dua to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Causa (Disaasa or injury that initiated avants resulting in deeth) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause ot death? 1☐ Yes 2☐ No

25. Was case referred to madical examiner? 1☒ Yas 2☐ No

26. Place ot Death (Chack only ona): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Homa 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Sulcida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, streat, tactory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifier (Check only one): 1☐ **Certifying Phyaician**: To tha bast ot my knowledga, daath occurred at the tima, data and place, and dua to tha causa(s) and manner as stated. 2☒ **Medical Examiner**: On the basis ot examination and/or investigation, in my opinion, daath occurred at the time, dete and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier: Mario F. Golle Jr. MD

29c. License number: D33954

29d. Date signed (Month, Dey, Year): DECEMBER 27, 1997

30. Name and address of person who compleated cause of death (Item 23a) (Type, Print): MARIO F. GOLLE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997

32. Ragistrar's Signeture

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be axecuted within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41234

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JUDITH A. VALLEY

2. Date of Death Month Dey Year: DEC. 22 1997

3. Time of Death: 1152

4a. Facility Name *(If not institution, give street and number)*: ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 492-50-7983

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 52 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG. 20 1945

9. Birthplace *(State or Foreign Country)*: MISSOURI

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: SEVERN

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 8218 TOMLINSON COURT

10f. Zip Code: 21144

10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+): 5 yrs.

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: UNDERWRITER

16b. Kind of Business/Industry: MARYLAND AUTOMIBLE INSURANCE FUND

17. Father's Name *(First, Middle, Last)*: OTIS TAYLOR

18. Mother's Name *(First, Middle, Maiden Surname)*: CATHERINE SHEPPARD

19a. Informant's Name/Relationship *(Type, Print)*: LENNARD VALLEY (HUSBAND)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8218 TOMLINSON COURT SEVERN, MD. 21144

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ANNAPOLIS MEM. GARDENS

Date: 12/30/97

20c. Location - City or Town, State: ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee: ▶ Larry S. Reese

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on aach lina.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Shock — Due to (or as a consequence of):

b. Pulmonary Embolism — Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last

c. Renal Cell Carcinoma — Due to (or as a consequence of):

d.

Suddenly

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Familial polyposis & colon cancer, adenocarcinoma, diabetes mellitus type 2, peripheral neuropathy, asthma, hypertension, cerebral CVA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings evelleble prior to compiation of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Nick Nicholas Moutsos MD

29c. License number: 008801

29d. Data signed *(Month, Day, Year)*: 12/22/1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 995 Aquahart Rd. Glen Burnie, Md 21061 Nicholas Moutsos

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997

32. Registrar's Signature: Julia Davidson-Randell

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41235

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CURTIS WORMELLE

2. Date of Death Month Day Year: December 26, 1997

3. Time of Death: 12:40 Am

4a. Facility Name *(If not institution, give street and number)*: Fairhaven Health Care Center

4b. City, Town, or Location of Death: Sykesville

4c. County of Death: Carroll County

Funeral Director

5. Social Security Number: 003-01-0883

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 26, 1911

9. Birthplace *(State or Foreign Country)*: Massachusettes

Usual Residence of Decedent

10a. State: MD

10b. County: Carroll County

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 7200 Third Avenue

10f. Zip Code: 21784

10g. Citizen of What Country?: U.S..A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Rece - American Indian, Bleck, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Collaga (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Claims Certifier

16b. Kind of Business/Industry: Claims

17. Fathar's Nama *(First, Middle, Last)*: Frederick Wormelle

18. Mothar's Nama *(First, Middle, Maidan Surnama)*: Grace Nickerson

19a. Informant's Name/Raiationship *(Type, Print)*: Mr. Lloyd Helt, Jr. (Attorney)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7600 Main Street Sykesville, MD 21784

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Nama of cemetary, cramatory or other piece)*: Carroll Cremation Serv.

Date: 12/27/97

20c. Location - City or Town, State: Hampstead, MD

21. Signatura of Funeral Service Licensaa: Brian L. Haight

22. Nama and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complicetions that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only ona causa on aach ilna.

Approximata Interval Between Onsat and Death

Immediate Ceuse (Finai diseese or condition resulting in daath)

a. PNEUMONIA — 6 WEEKS

Dua to (or es e consequence of):

b. DYSPHAGIA

Sequantially list conditions, if eny, leading to immadiate ceuse. Entar Underlying Causa (Disaasa or injury thet initiated avants rasulting in daath) Last

Dua to (or as a consequence of):

c. CEREBROVASCULAR DISEASE

Dua to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in tha undarlying cause givan in Part I.

DIABETES MELLITUS

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to compiation of causa of death? 1 [ ] Yas 2 [ ] No

25. Was case rafarred to medical examinar? 1 [ ] Yas 2 [X] No

26. Place of Daath *(Check only ona)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Othar: 4 [X] Nursing Homa 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Mennar of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be datarmined

28a. Data of injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To tha best of my knowladga, daath occurred at tha time, dete and place, end dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurred at tha time, data and place, end due to the cause(s) and menner steted.

29b. Signature and title of certifier: Ellis Mez MD

29c. License number: D22220

29d. Dete signad *(Month, Day, Yaar)*: December 26, 1997

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print): Ellis Mez, M.D. 7200 Third Avenue, Sykesville, MD 21784

State Registrar

31. Data filad *(Month, Day, Yaar)*: DEC 29 1997

32. Registrar's Signature: Julia Shudson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41236

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John B Williams

2. Date of Death: Month 12 Day 27 Year 97

3. Time of Death: 11:35 AM

4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM

4b. City, Town, or Location of Death: BALTIMORE, MD

4c. County of Death:

Funeral Director

5. Social Security Number: 579-96-6445

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 22 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 8-21-75

9. Birthplace (State or Foreign Country): WASHINGTON, D.C

Usual Residence of Decedent

10a. State: MD

10b. County: P.G.

10c. City, Town or Location: FORESTVILLE

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2735 LORRING DR

10f. Zip Code: 20747

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SCHOOL

16b. Kind of Business/Industry: UNEMPLOYED

17. Father's Name (First, Middle, Last): JOHN H. WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname): DOREATHEA WINESTOCK

19a. Informant's Name/Relationship (Type, Print): CALVIN WINESTOCK

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 336 ADAMS ST.N.E. APPT. B. WASH.D.C. 20002

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HARMONY CEMETERY

Date: 1/3/98

20c. Location - City or Town, State: LANDOVER, MD.

21. Signature of Funeral Service Licensee: James E. Williams

22. Name and Address of Facility: THE HOUSE OF WILLIAMS FUNERAL SERVICEAS 411 KENNEDY ST.N.W. WASHINGTON, D.C. 20011

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Heart failure — 1 year

Due to (or as a consequence of): b. Cardiomyopathy — 10 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Borchelt MD

29c. License number: D44498

29d. Date signed (Month, Day, Year): 12/27/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): BRET BORCHELT, MD 22 S. GREENE ST BALTIMORE, MD 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998

32. Registrar's Signature: Julia Thurston Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41237

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LEVI WASHINGTON
2. Date of Death: Month Dec, Day 29, Year 97
3. Time of Death: 6:55 am
4a. Facility Name (If not institution, give street and number): Allegis Health-Bethesda
4b. City, Town, or Location of Death: Bethesda
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 248-12-6415
8. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): June 23 1917
9. Birthplace (State or Foreign Country): Edgefield SC

Usual Residence of Decedent

10a. State: MD
10b. County: PG
10c. City, Town or Location: Ft Washington
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 6704 Trowbridge Place
10f. Zip Code: 20744
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Construction Laborer
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Luther Washington Sr
18. Mother's Name (First, Middle, Maiden Surname): Louella Frazier

19a. Informant's Name/Relationship (Type, Print): Brenda Thomas/Niece
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6704 Trowbridge Place, Ft Washington MD 20744

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Forest Hill Memorial Park
Date: 1/3/98
20c. Location - City or Town, State: Clinton, MD

21. Signature of Funeral Service Licensee: Robert A. Litt
22. Name and Address of Facility: Robert G. Mason Funeral Home, 1661 Good Hope Rd SE, Washington DC 20020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Pneumonia — Week

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joel Schulman MD
29c. License number: D20516
29d. Date signed (Month, Day, Year): Dec 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Joel Schulman MD 9715 Old Georgetown Rd Bethesda MD 20814

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998
32. Registrar's Signature: Julia Thompson Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41238

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William WRIGHT

2. Date of Death (Month, Day, Year): Dec 27, 1997

3. Time of Death: 06:30pm

4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death: SILVER SPRING

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 243-20-2155

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 20, 1920

9. Birthplace (State or Foreign Country): N. Carolina

Usual Residence of Decedent

10a. State: Md.

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 11442 Connecticut Avenue

10f. Zip Code: 20895

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Tractor Trailer Driver

16b. Kind of Business/Industry: Private Industry

17. Father's Name (First, Middle, Last): William Wright, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Mary Wright

19a. Informant's Name/Relationship (Type, Print): Harvey Wright (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11442 Connecticut Ave., Kensington, MD. 20895

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Quantico Nat. Cemetery

Date: 1-2-98

20c. Location - City or Town, State: Quantico, VA.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Ralph Williams Funeral Service, 517 - 11th Street, SE; Wash., DC

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Respiratory failure	Sudden
Due to (or as a consequence of): b.	Pleural Effusion	Days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last. Due to (or as a consequence of): c.	Congestive heart failure	Months
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Stroke

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. License number: D-32332

29d. Date signed (Month, Day, Year): Dec. 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SK GUPTA MD 9801 Georgia Ave #220 SILVER SPRING Md 20902

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998

32. Registrar's Signature: Julia Thurston Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41239

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Shavn Walker

2. Date of Death Month: December Day: 23 Year: 1997

3. Time of Death: 9:35 pm

4a. Facility Name *(If not institution, give street end number)*: MONTGOMERY GENERAL

4b. City, Town, or Location of Death: OLNEY

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 220-11-0214

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 31 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: MAY 14, 1966

9. Birthplace *(State or Foreign Country)*: GUYANA GEORGIOWN,

Usual Residence of Decedent

10a. State: MD.

10b. County: MONTGOMERY

10c. City, Town or Location: SILVER SPRING

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 4039 CHESTERWOOD DRIVE

10f. Zip Code: 20906

10g. Citizen of Whet Country?: GUYANA

11. Merital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12th GRADE; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MAINTENANCE

16b. Kind of Business/Industry: PRIVATE INDUSTRY

17. Father's Name *(First, Middle, Last)*: NEVILLE A. WALKER

18. Mother's Name *(First, Middle, Meiden Surneme)*: WINNIFRED P. ISACCS

19a. Informant's Name/Retationship *(Type, Print)*: WINNIFRED P. ISACCS

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 4039 CHESTERWOOD DR. SILVER SPRING MD. 20906

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: GATE OF HEAVEN CEMETERY

Dete: 12/29/97

20c. Location - City or Town, State: SILVER SPRING, MD.

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: JOHNSON & JENKINS FUNERAL HOME 716 KENNEDY ST NW WDC 20011

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximete Interval Between Onset end Death

Immediate Cause (Finel diseese or condition resulting in death)

a. Toxoplasmosis — One month

Due to (or as a consequence of):

b. Acquired Immune Deficiency — Two Years

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Piece of Death *(Check only one)*: Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) and menner stated.

29b. Signature end title of certifier: [signature]

29c. License number: D33886

29d. Date signed *(Month, Dey, Year)*: December 24, 1997

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Kenneth Miller, MD 18111 Prince Phillip Dr. Olney, MD 20832

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed *(Month, Dey, Year)*: DEC 29 1997

32. Registrer's Signature: Julie Henderson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

CP Walker, Shavn 12/23/97 9:35 PM

(3)

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41240

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
FRANCIS	WHITAKER	DECEMBER 19,1997	8:30pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
706 CASTLEWOOD PL.	UPPER MARLBORO	P.G. COUNTY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-50-5230	1☐ M 2☒ F	89 Yrs.			MAY 14,1908	TARBORO NC

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	P.G. COUNTY	UPPER MARLBORO	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
706 CASTLEWOOD PL	20774	usa

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Americen indian, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
9		DOMESTIC	PRIVATE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
UNKNOWN	ELEANOR BULLOCK

19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JOYCE WOOD /DAUGHTER	706 CASTLEWOOD PL UPPER MARLBORO MD 20774

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremetion 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)	MD NATONAL CEMETERY	12-24-97	LAUREL MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Alex S. Pope Jr	ALEXANDER S.POPE FUNERAL HOMES 5538 MARLBORO PIKE FORESTVILLE MD 20747

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Causa (Final diseasa or condition resulting in death) a.	ANEMIA	5yrs
Due to (or as a consequence of):		
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest b.	CHRONIC GASTROINTESTINAL BLEEDING	5yrs
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminer?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and piece, end due to the ceuse(s) end manner as stated.
2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner steted.

29b. Signeture and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	H0052080	12-23-97

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print)
Gary R Gray D.O. 4151 Bladensburg Rd Colmar Manor MD 20737

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
DEC 29 1997	Julia Henderson Randall

Baltimore, Maryland 21215-0020
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41241

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Elizabeth Wakeman

2. Date of Death (Month, Day, Year): December 26, 1997

3. Time of Death: 12:30 P

4a. Facility Name (If not institution, give street and number): 2414-57th Ave

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 578-09-2523

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 29, 1912

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George

10c. City, Town or Location: Cheverly

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2414-57th Avenue

10f. Zip Code: 20785

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Ora Overholser

18. Mother's Name (First, Middle, Maiden Surname): Marie Peckover

19a. Informant's Name/Relationship (Type, Print): Christina L. Mileo /Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2414-57th Ave., Cheverly, MD 20785

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chambers Crematory

Date: 12/27/97

20c. Location - City or Town, State: Riverdale, MD

21. Signature of Funeral Service Licensee: Bernie L. Jenkins M1014

22. Name and Address of Facility: Chambers Funeral Home.P.A. 5801 Cleveland Ave., Riverdale, MD 20737

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. alzheimer's disease, terminal — 10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☑ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D13339

29d. Date signed (Month, Day, Year): 12/26/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): T. Chanchien, M.D., P.A., 8824 Cunningham Drive, Ste. A, Berwyn Heights, MD 20740

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997

32. Registrar's Signature: John Davidson Rardall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41242

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALLAN K. C. WANG

2. Date of Death Month / Day / Year: DECEMBER 12, 1997

3. Time of Death: 6:20 AM

4a. Facility Name *(If not institution, give street and number)*: GLADYS SPELLMAN NURSING CENTER

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 577-04-6670

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: MAR. 12, 1916

9. Birthplace *(State or Foreign Country)*: CHINA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: PRINCE GEORGE'S

10c. City, Town or Location: UPPER MARLBORO

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 124 WEYMOUTH STREET

10f. Zip Code: 20772

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* CHINESE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SALES PERSON

16b. Kind of Business/Industry: FOOD & BEVERAGE

17. Father's Name *(First, Middle, Last)*: WEN TIEN WANG

18. Mother's Name *(First, Middle, Maiden Surname)*: SHUI YUNG WANG

19a. Informant's Name/Relationship *(Type, Print)*: KEN WANG, GRANDSON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 124 WEYMOUTH ST., UPPER MARLBORO, MD 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: FORT LINCOLN CEMETERY | Date: 12/20/97

20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: Lisa S. Johnson

22. Name and Address of Facility: FORT LINCOLN FUNERAL HOME, 3401 BLADENSBURG RD., BRENTWOOD, MD 20722

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) a. Dementia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D41978

29d. Date signed *(Month, Day, Year)*: 12-22-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): N. Lavakoh M.D. 2077 Doit Chevy MD 20785

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997

32. Registrar's Signature: Julia Brudnar Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

3

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41243

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Cordelia White

2. Date of Death (Month, Day, Year): Dec. 21, 1997

3. Time of Death: 7:27p.m.

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Mont.

Funeral Director

5. Social Security Number: 578 36 7784

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Mar. 23, 1918

9. Birthplace (State or Foreign Country): Danville, Va.

Usual Residence of Decedent

10a. State: DC

10b. County: N/A

10c. City, Town or Location: Washington, D.C.

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2416 10th St., N.E.

10f. Zip Code: 20018

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondery (0-12): 8th grade
College (1-4or 5+): NONE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House Keeper

16b. Kind of Business/Industry: HOMEMAKER

17. Father's Neme (First, Middle, Last): Harry Farmer

18. Mother's Name (First, Middle, Maiden Surname): Mammie Walters

19a. Informant's Neme/Reletionship (Type, Print): Joan Gravely / Cousin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2014 Wardman Rd. Hyattsville, Md. 20782

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery

Date: 12/26/97

20c. Location - City or Town, State: Brentwood, Md.

21. Signature of Funeral Service Licensee: Juan Smith

22. Name and Address of Facility: John T. Rhines Co. 3030 12th St., N.E. Wash., D.C. 20017

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

5

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Finat disease or condition resulting in death): a. Sepsis — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

b.

Due to (or as a consequenca of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy tindings available prior to completion of cause of death? 1☐ Yes 2☒ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, tarm, street, factory, offica building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examination end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated.

29b. Signature and title of cartifier: T. S. Anthony

29c. License number: D 50300

29d. Date signed (Month, Day, Year): Dec. 23, 1997

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): Thomas J. Anthony, MD 11119 Rockville Pike #316 Rockville, Md. 20852

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997

32. Registrar's Signature: Heather Rachell

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CARDELIA White Dec 21, 1997 7:27 PM

(5)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41244

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: HOLLIS JAMES WHITE SR.

2. Date of Death — Month: DECEMBER Day: 24 Year: 1997

3. Time of Death: 08:45PM

4a. Facility Name *(If not institution, give street and number)*: 5024 54TH PLACE

4b. City, Town, or Location of Death: HYATTSVILLE

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 244-28-2868

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 70 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: November 6,1927

9. Birthplace *(State or Foraign Country)*: Seneca,S.C.

Usual Residance of Decedant

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 5024 - 54th Place

10f. Zip Coda: 20781

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Merried 3 [X] Widowad 4 [ ] Divorcad

12. Was Decedant Evar in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No — If Yas, Giva Year or Dates: 1945-47

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puarto Ricen, atc.): 1 [ ] Yas 2 [X] No *Specify:*

14. Race - Americen Indian, Black, White, atc. *Specify:* White

15. Decedent's Educetion *(Specify only highest grada completed)*: Elementery/Secondary (0-12): 12 — Collega (1-4or 5+):

16a. Decedent's Usuel Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: Armored Services Guard

16b. Kind of Businass/Industry: Dunbar Armored

17. Fathar's Name *(First, Middle, Last)*: William Henry White

18. Mothar's Nama *(First, Middle, Maidan Sumama)*: Alma Stephens

19a. Informant's Name/Relationship *(Type, Print)*: Hollis James White,Jr./son

19b. Mailing Address *(Straet end Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 15300 Candy Hill Rd.,Upper Marlboro,MD 20772

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Nama of camatary, cramatory or othar place)*: Maryland Veterans Cemetery — Data: 12/30/97

20c. Location - City or Town, State: Cheltenham,Maryland

21. Signature of Funerel Service Licensee: ▶ H Constance Gasch

22. Nama and Address of Facility: Francis Gasch's Sons Funeral Home,P.A. 4739 Baltimore Avenue,Hyattsville,MD 20781

GC

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complicetions that ceused tha daath. Do not antar tha moda of dying, such as cerdiac or raspiretory arrast, shock, or haart failura. List only ona causa on aach line.

Approximate Interval Between Onsat and Death

Immadiata Causa (Final disaasa or condition rasulting in daath)

a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Dua to (or as a consequence of):

Sequantially list conditions, if any, leading to immadiate ceusa. Enter Underlying Causa (Disaase or injury thet initieted avants rasulting in daath) Last

b.

Dua to (or as e consequance of):

c.

Dua to (or es e consequanca of):

d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha underlying ceusa given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings available prior to compilation of ceusa of daath? 1 [ ] Yas 2 [ ] No

25. Was cesa referred to medical examinar? 1 [X] Yas 2 [ ] No

26. Place of Death *(Check only ona)*: Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA — Othar: 4 [ ] Nursing Homa 5 [X] Residence 8 [ ] Other *(Specify)*

27. Mennar of Daath: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, straat, factory, office building, atc. *(Spacify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Phyaician:** To tha best of my knowledge, daath occurred at tha tima, data and place, and dua to the ceusa(s) and manner as stated. 2 [X] **Medical Examinar:** On the basis of axamination and/or investigation, in my opinion, daath occurred at the time, date and place, and dua to the causa(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MME D 33954

29c. License number

29d. Data signed *(Month, Day, Year)*: DECEMBER 29, 1997

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F. GOLLE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Data filed *(Month, Day, Yaar)*: DEC 30 1997

32. Registrar's Signature: John Alexander Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

1 VAC 10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41245

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JACQUELYNE WILEY
2. Date of Death (Month, Day, Year): DECEMBER 25 1997
3. Time of Death: 12:50 pm
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: 577-82-7375
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 33 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 29, 1964
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: New Carrollton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5428 85th Avenue, #201
10f. Zip Code: 20784
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Lawyer
16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Anthony Wiley
18. Mother's Name (First, Middle, Maiden Surname): Margaret Lewis

19a. Informant's Name/Relationship (Type, Print): Carolyne D. Newman - Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3410 Bonita Street, Suitland, MD 20746

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park
Date: 12/30/97
20c. Location - City or Town, State: Landover, MD

21. Signature of Funeral Service Licensee: John T. Stewart III
22. Name and Address of Facility: STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E., Washington, D. C.

Physician /Medical Examiner

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	3weeks
Due to (or as a consequence of): b.	Bone Marrow Transplant	2months
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	Chronic Myelogenous Leukemia	1year
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
28. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Lawrence Gardner MD
29c. License number: D50559
29d. Date signed (Month, Day, Year): December 25 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Lawrence Gardner 600 North Wolfe Street Baltimore MD 21287

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997
32. Registrar's Signature: Julia Heathcock Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(4)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41246

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Jane White

2. Dete of Death Month Dey Yeer: December 19, 1997

3. Time of Death: 8:37 AM

4e. Facility Nama *(If not institution, give street end number)*: THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death:

Funeral Director

5. Social Security Number: 006-10-6323

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. lest birthdey)*: 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Yeer): Oct 23, 1919

9. Birthplece *(State or Foraign Country)*: MASS.

Usuel Residence of Decedent

10e. Stete: VA

10b. County: ORANGE

10c. City, Town or Location: LOCUST GROVE

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 129 Gold RUSH DR.

10f. Zip Code: 22508

10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1☐ Never Merried 2☒ Marriad 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Yaar or Detes:

13. Was Dacedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - Amarican Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completad)*: Elementary/Secondary (0-12): / College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work dona during most of working life. DO NOT use retired)*: Nurse

16b. Kind ot Business/Industry: Medical

17. Father's Neme *(First, Middle, Last)*: FREDERICK DUNHAM TRAPP

18. Mother's Name *(First, Middle, Meiden Surneme)*: Marion Wylson

19a. Informant's Name/Reletionship *(Type, Print)*: Robert Alan White

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: HC 72 Box 537A Locust Grove

20e. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☐ Removal from State 4☒ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or other piece)*: HOWARD UNIVERSITY

Dete: Dec. 30 1997

20c. Location - City or Town, Stata: WASHINGTON, DC

21. Signetura of Funeral Service Licensee:

22. Name end Addrass of Facility: AAMAN FUNERAL SERVICE 1601 Kenilworth Ave, NE, Washington, DC

Physician /Medical Examiner

23e. Pert. Enter the diseese, or complications thet caused tha deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceusa on each line.

		Approximete Interval Between Onset and Deeth
Immediete Cause (Final diseese or condition resulting in deeth) e.	anoxic brain injury	6 days
Due to (or es a consequence of): b.	emphysema	50 years
Sequentielly list conditions, if any, leading to immadiete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last — Due to (or as e consequence of): c.	bilateral pneumothoraces	6 days
d.		

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.: hypertension

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveilable prior to completion of causa of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yas 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Hama 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Deta of Injury *(Month, Dey Yeer)*:

28b. Tima of Injury:

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*:

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best ot my knowledge, death occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exemination end/or investigation, In my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier: MD

29c. License number: RES-000

29d. Date signed *(Month, Day, Yeer)*: December 19, 1997

30. Name and eddress ot person who completed cause of deeth (Item 23e) (Type, Print): Johns Hopkins Hospital, Baltimore, Maryland

State Registrar

31. Dete filed *(Month, Day, Yeer)*: DEC 30 1997

32. Registrar's Signature:

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97-7529-033
B.K.S

ANTHONY WILKINS
Items:23a part I,27 per MEO G-755 1/16/98 dh

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41247
Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anthony Reginald Wilkins
2. Date of Death Month Day Year: DEC. 29, 1997
3. Time of Death: 0048 AM
4a. Facility Name *(If not institution, give street and number)*: PRINCE GEORGES HOSPITAL CENTER
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 217-60-7641
6. Sex: 1☐M 2☐F XX
7. Age *(In yrs. last birthday)*: 45 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12/26/1952
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: Md.
10b. County: PG
10c. City, Town or Location: Capitol Heights
10d. Inside City Limits: 1☐Yes 2☐No XX
10e. Street and Number: 206 East Mill Avenue
10f. Zip Code: 20743
10g. Citizen of Whet Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 2
16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Master Plumber
18b. Kind of Business/Industry: Self

17. Father's Name *(First, Middle, Last)*: Russell G. Wilkins
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Helen Williams

19e. Informant's Name/Relationship *(Type, Print)*: Gregory M. Wilkins/Brother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 206 East Mill Avenue Capitol Heights,Md 20743

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery
Date: 1/2/98
20c. Location - City or Town, State: Brentwood, Md.

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Dunn & Sons 5635 Eads St. NE DC 20019

Physician Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one ceuse on each line. — Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or es e consequence of):
Sequentiellty list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initiated events resulting in deeth) Last
b.
Due to (or es e consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cauee of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were eutopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☒No
28d. Describe how Injury occurred
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es steted.
2☒ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to tha ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Year)*: DEC. 29, 1997

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Dennis J. Chutend 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41248

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MAE GENEVIEVE WAGNER
2. Data of Death (Month, Day, Year): DECEMBER 25, 1997
3. Time of Death: 4:23 P.M.
4a. Facility Name *(If not institution, give street and number)*: CUMBERLAND NURSING HOME
4b. City, Town, or Location of Death: CUMBERLAND
4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 213-22-3746
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 93 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: AUG. 4, 1904
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ALLEGANY
10c. City, Town or Location: CUMBERLAND
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 808 GREENE STREET
10f. Zip Code: 21502
10g. Citizen of What Country?: U.S.A.
11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): UNKNOWN; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: STUDENT NURSE SUPERVISOR
16b. Kind of Business/Industry: HOSPITAL
17. Father's Name *(First, Middle, Last)*: JOHN B. T. JENKINS
18. Mother's Name *(First, Middle, Maiden Surname)*: ANNA MAY WOLFE
19a. Informant's Name/Relationship *(Type, Print)*: JOHN JENKINS / NEPHEW
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1609 FREDERICK STREET, CUMBERLAND, MD 2 1502
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ROSE HILL CEMETERY
Date: 12/29/97
20c. Location - City or Town, State: CUEMBERLAND, MD
21. Signature of Funeral Service Licensee: ▶ Wendy A. Upchurch
22. Name and Address of Facility: UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Uraemia — 3 weeks

Due to (or as a consequence of):
b. Chronic renal failure — 12 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: COPD

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Peter Schwartz MD
29c. License number: DO 4981
29d. Date signed *(Month, Day, Year)*: December 26 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): P. HALM. S 302 Schley St. Cumberland, Md.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3 of 3

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 29 1997
32. Registrar's Signature: ▶ Julia Strickland-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene — *Certificate of Death*

Clara B Warren — Reg. No. 97 41249

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Clara B. Warren
2. Data of Death — Month: Dec; Day: 27; Year: 1997
3. Time of Death: 11:15am
4a. Facility Name *(If not institution, give street and number)*: Lions Manor Nursing Home
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 168-28-3249
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs.
If Under 1 Year — Months: ; Days:
If Under 24 Hrs. — Hours: ; Min.:
8. Data of Birth *(Month, Day, Year)*: Dec 7, 1909
9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 15614 Yoder Court SW
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Bernard J. Cejrowski
18. Mother's Name *(First, Middle, Maiden Surname)*: Cecilia V. (NMN)

19a. Informant's Name/Relationship *(Type, Print)*: Carolyn Barron-daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15614 Yoder Court SW Cumberland MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resurrection Cemetery
Date: 12/30
20c. Location - City or Town, State: Coraopolis, PA

21. Signature of Funeral Service Licensee: ▶ James J Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home Cumberland MD 21502

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Peptic ulcer disease c GI bleed — 1 day

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Severe Alzheimers disease, S/P C.V.A
Diabetes Mellitus, bilateral blindness

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Date of Injury *(Month, Day, Year)*:
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred:
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ V.A. Ranjithan
29c. License number: D 19750
29d. Date signed *(Month, Day, Year)*: Dec 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VA Ranjithan MD, Lions Manor Nursing Home, Seton Drive Ext., Cumberland MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997
32. Registrar's Signature: ▶ Julie Bradshaw Rudd

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41250

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: MARY KATHERINE WEAKLEY
2. Dete of Deeth Month Dey Year: December 30, 1997
3. Time of Deeth: 7:55 am
4a. Facility Neme *(If not institution, give street end number)*: Memorial Hospital & Medical Center
4b. City, Town, or Location of Deeth: Cumberland
4c. County of Deeth: Allegany

Funeral Director

5. Sociel Security Number: 220-10-0230
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. lest birthday)*: 85 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Jul 11, 1912
9. Birthpiece *(State or Foreign Country)*: WV

Usuel Residence of Decedent

10e. Stete: WV
10b. County: Mineral
10c. City, Town or Location: Ridgeley
10d. Ineide City Limits: 1☐ Yes 2☒ No
10e. Street end Number: Route 1
10f. Zip Code: 26753
10g. Citizen of What Country?: USA
11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: white
15. Decedent's Education *(Specify only highest grede completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Fether's Neme *(First, Middle, Last)*: William Harrison Miller
18. Mother's Neme *(First, Middle, Meiden Surneme)*: Anna Marie (Steckman)
19a. Informent's Neme/Relationship *(Type, Print)*: Agnes M. James--daughter
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: Route 1; Ridgeley, WV 26753
20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Cumberland Crematory
Dete: 12/30
20c. Location - City or Town, Stete: Cumberland, MD
21. Signeture of Funeral Service Licensee: Nicholas J Scarpelli
22. Neme end Address of Facility: Scarpelli Funeral Home, P.A. Cumberland, MD 21502

Physician /Medical Examiner

23e. Pert I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximete Intervel Between Onset end Deeth

Immediate Ceuse (Finel diseese or condition resulting in deeth): e. Acute CerebroVascular Accident — Two Weeks

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to Immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: Hypertension

23b. Did tobecco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No

28. Piece of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: Sunil Gupta

29c. License number: D 33280

29d. Date signed *(Month, Dey, Yeer)*: December 30, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Dr. Sunil Gupta-Johnson Heights Medical Building-Cumberland, MD 21502

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 30 1997
32. Registrer's Signeture: Julia [illegible]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Nov 2

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41251

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Howard Herbert Wilson
2. Dete of Death Month Day Yeer: DECEMBER 28, 1997
3. Time of Death: 9:06 A.M.
4a. Feciity Neme *(If not institution, give street and number)*: Sacred Heart Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Deeth: Allegany

Funerai Director

5. Social Security Number: 220-30-8329
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 63 Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: October 5, 1934
9. Birthpieca *(Stete or Foreign Country)*: MD

Usual Residence of Decedent

10a. Stata: MD
10b. County: Allegany
10c. City, Town or Location: Lonaconing
10d. inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 23 High Street
10f. Zip Code: 21539
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Nevar Merried 2☒ Merried 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- tf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*
14. Race - Amarican Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 10 — College (1-4or 5+): 0
16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DD NDT use retired)*: Laborer
16b. Kind of Business/Industry: Lumber

17. Father's Neme *(First, Middle, Last)*: Joseph A. Wilson
18. Mother'e Name *(First, Middle, Maiden Surneme)*: Mary Beeman

19e. Informent's Name/Reletionship *(Type, Print)*: Violet Wilson wife
19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 23 High Street Lonaconing, MD 21539

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removei from State 4☐ Donation 5☐ Other *(Spacify)*
20b. Pieca of Disposition *(Neme of cemetery, cremetory or other piece)*: Laurel Hill Cemetery — Date: Dec. 31, 1997
20c. Location - City or Town, Stete: Moscow Mills, MD

21. Signeture of Funarel Service Licansea: ▶ James E McKenzie
22. Name and Address of Feclity: Eichhorn-McKenzie Funeral Home P.A. 8 E. Main Street Lonaconing, MD 21539

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Pert1. Enter the diseesa, or complicetions thet caused the death. Do not enter tha mode of dying, such es cardiac or respiretory errest, ahock, or heert feilure. List only one ceuse on eech line.

Approximete intervel Between Onset and Deeth

Immediete Ceuse (Finel disaase or condition resulting in deeth)
e. MYOCARDIAL INFARCTION — 1 hour

Due to (or as a consequence of):
b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 7 YRS

Sequentially list conditions, if eny, leeding to immediete cause. Enter Underlying Ceusa (Disease or injury thet initieted events resulting in deeth) Last

Due to (or es a consequenca of):
c.

Due to (or es a consequenca of):
d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Pert i.

Cigarette abuse
hypercholesterolemia

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveilable prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Deeth *(Check only one)*: Hospitel: 1☐ Inpatient 2☑ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturei 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending invastigation 6☐ Could not be detarmined

28a. Dete of injury *(Month, Dey Year)*
28b. Time of injury M
28c. Injury et Work? 1☐ Yas 2☐ No
28d. Describe how injury occurred
28e. Pieca of Injury - At home, farm, streat, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowladge, deeth occurred et the time, date end pieca, and due to the ceuse(s) and menner es stated. 2☐ **Medical Examinar**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and piece, end due to the cause(s) end mennar steted.

29b. Signeture end title of certifier: ▶ Donald Manger
29c. Licansa number: D05231
29d. Dete signed *(Month, Dey, Year)*: DECEMBER 28 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): DONALD MANGER 11600 Bidstrup Road N.E. CUMBERLAND MD 21502

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

TMS

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 31 1997
32. Registrer's Signature: Julia Thurston Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41252

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BETTY LOUISE WHITFORD

2. Date of Death Month: December Day: 26 Year: 1997

3. Time of Death: 1138

4a. Facility Name *(If not institution, give street and number)*: WASHINGTON CO HOSPITAL

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 212-24-1398

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 70 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: SEPT 5 1927

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WASHINGTON

10c. City, Town or Location: HAGERSTOWN

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 807 WASHINGTON STREET

10f. Zip Code: 21740

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexlcan, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Bieck, White, etc. Specify: WHITE

15. Decedent's Educetion *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSE KEEPER

16b. Kind of Business/Industry: HOUSE KEEPER

17. Fether's Neme *(First, Middle, Last)*: JOSEPH HENRY KOELKER

18. Mother's Name *(First, Middle, Meiden Surneme)*: ADA MARIE LAYMAN

19a. Informent's Name/Relationship *(Type, Print)*: BETTY ANN TAYLOR DAUGHTER

19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 807 WASHINGTON STREET HAGERSTOWN, MARYLAND 21740

20e. Method of Disposition: 1☐ Buriai 2☒ Cremetion 3☐ Removei from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: CUMBERLAND CREMATORY

Date: DEC 27 1997

20c. Location - City or Town, Stete: CUMBERLAND MARYLAND

21. Signature of Funerel Service Licensee: Dale L. Merritt

22. Neme end Address of Fecility: MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.

Approximete Intervel Between Onset end Deeth

Immedete Ceuse (Finel disease or condition resulting in deeth)

a. ACUTE RESPIRATORY FAILURE — SUDDEN

Due to (or es e consequence of):

Sequentially list conditions, if eny, leeding to Immedete ceuse. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Last

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — YEARS

Due to (or es a consequence of):

c.

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.: PULMONARY CARCINOMA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigetion 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Yeer)*: NONE

28b. Time of Injury: M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and piece, and due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, dete end piece, end due to the ceuse(s) end manner steted.

29b. Signeture end title of certifier: Barry M. Cohen, MD

29c. License number: D01040

29d. Dete signed *(Month, Day, Year)*: 12-27-97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): BARRY M. COHEN, MD 18706 CRESTWOOD DRIVE, HAGERSTOWN, MD 21742

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: DEC 31 1997

32. Registrer's Signature: Gibi Hamilton-Kendall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Betty Louise Whitford

4

MS

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41253

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GEORGE LEWIS WEHLER

2. Date of Death (Month, Day, Year): DECEMBER 29 1997

3. Time of Death: 10:25 AM

4a. Facility Name (If not institution, give street and number): SACRED HEART HOSPITAL

4b. City, Town, or Location of Death: CUMBERLAND

4c. County of Death: ALLEGANY

Funeral Director

5. Social Security Number: 199 05 8096

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): MAY 13, 1918

9. Birthplace (State or Foreign Country): PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ALLEGANY

10c. City, Town or Location: FROSTBURG

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 75 BROADWAY

10f. Zip Code: 21532

10g. Citizen of What Country?: U.S.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 7

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): MINISTER

16b. Kind of Business/Industry: CHURCH

17. Father's Name (First, Middle, Last): CHARLES WEHLER

18. Mother's Name (First, Middle, Maiden Surname): MAGGIE EISENHART

19a. Informant's Name/Relationship (Type, Print): SUZANNE WEHLER / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 75 BROADWAY, FROSTBURG, MD 21532

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): FROSTBURG MEMORIAL PARK

Date: 1/1/98

20c. Location - City or Town, State: FROSTBURG, MD 21532

21. Signature of Funeral Service Licensee: Marilou M. Sowers

22. Name and Address of Facility: SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	RESPIRATORY FAILURE	2 weeks
Due to (or as a consequence of): b.	CONGESTIVE Heart failure	2 mos
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	CAD	5 yrs
Due to (or as a consequence of): d.	COPD, SEVERE	5 yrs

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year):

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify):

28f. Location (Street and Number or Rural Route Number, City or Town, State):

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Angelo Roque MD

29c. License number: D 13166

29d. Date signed (Month, Day, Year): Dec 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANGEL H. ROQUE MD 48 Tann Terrace Frostburg Md 21532

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998

32. Registrar's Signature:

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41254

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Irvin L. Walters

2. Date of Death (Month, Day, Year): December 30, 1997

3. Time of Death: 5:45 P.M.

4a. Facility Name (If not institution, give street and number): Egle Nursing Home

4b. City, Town, or Location of Death: Lonaconing

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 220-10-2656

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 10, 1908

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD

10b. County: Allegany

10c. City, Town or Location: Lonaconing

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 88 E. Main Street

10f. Zip Code: 21539

10g. Citizen of What Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispenic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Reca - American Indlen, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 5

College (1-4or 5+): 0

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Trackman

16b. Kind of Business/Industry: Railroad

17. Father's Name (First, Middle, Last): Richard Walters

18. Mother's Name (First, Middle, Maiden Surname): Mahaley Coleman

19e. Informent's Name/Relationship (Type, Print): Priscillia Ritchey Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14406 National Hwy S.W. LaVale, MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other place): Frostburg Memorial Park

Date: Jan. 3 1998

20c. Location - City or Town, Stete: Frostburg, MD

21. Signature of Funeral Service Licensee: James E. McKee

22. Name and Address of Facility: Eichhorn-McKenzie Funeral Home P. A. 8. E. Main Street Lonaconing, MD 21539

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in death)

e. Cardiac Myopathy — 2 mos

Due to (or as a consequence of):

b. Generalized Arteriosclerosis — 5 yrs.

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest

Due to (or as a consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Advanced Alzheimers Dementia

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Plece of Deeth (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

2☐ **Medical Examiner:** On the besis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end plece, end due to the cause(s) and menner stated.

29b. Signeture end title of certifier: L. Miles MD

29c. License number: D07004

29d. Date signed (Month, Day, Year): Dec. 31, 1997

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): L.R. MILES, JR., M.D. 57 JACKSON ST. LONACONING MD 21539

State Registrar

31. Dete filed (Month, Day, Year): JAN 05 1998

32. Registrar's Signature: Julie Hartman Rinker

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth end Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41255

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT L WISE

2. Date of Death — Month: DEC Day: 01 Year: 1997

3. Time of Death: 0540

4a. Facility Name (If not institution, give street and number): MEDPOINTE CONTINUING CARE

4b. City, Town, or Location of Death: ELKTON

4c. County of Death: CECIL

Funeral Director

5. Social Security Number: 215-28-7302

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Data of Birth (Month, Day, Year): MAR 21 1933

9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decadent

10a. State: MD

10b. County: HARFORD

10c. City, Town or Location: ABERDEEN

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 220 MAYBERRY DR APT 201

10f. Zip Code: 21001

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No If Yas, Giva Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No Specify:

14. Raca - Amarican Indian, Black, Whita, atc. Specify: BLACK

15. Decedent's Education (Specify only highast grada completed): Elamantary/Sacondary (0-12): 11 Collaga (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratirad): MAINTENANCE

16b. Kind of Businass/Industry: HOSPITAL

17. Fathar's Nama (First, Middla, Last): ROBERT SIMMS

18. Mothar's Nama (First, Middla, Maidan Sumama): MARY SIMS

19a. Informant's Name/Relationship (Type, Print): GEORGIA WISE - WIFE

19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 220 MAYBERRY DR APT 201 ABERDEEN MD 21001

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): GREEN MOUNT

Data: Dec 4, 1997

20c. Location - City or Town, State: BALTIMORE, MD.

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: BEARD FUNERAL HOME 552 LEWIS ST HAVRE DE GRACE, MD 21078

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Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on each line.

Approximata Intarval Batwaen Onset and Death

Immediata Causa (Final disaasa or condition rasulting in death)

a. Coronary Artery disease — Due to (or as a consequence of): — 1 year

Sequantially list conditions, if any, leading to immadiata ceuse. Entar Underlying Causa (Disaase or Injury that initiated evants rasulting in death) Last

b. Dua to (or as a consequance of):

c. Dua to (or as a consequance of):

d.

Part fi. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part i.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Ware autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [X] No

25. Was casa rafarred to medical examinar? 1 [ ] Yas 2 [X] No

26. Placa of Daath (Check only ona) — Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatiant 3 [ ] DOA — Othar: 4 [X] Nursing Homa 5 [ ] Rasidance 6 [ ] Othar (Specify)

27. Mannar of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be datarmined

28a. Data of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28a. Placa of injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifiar (Check only one): 1 [X] **Certifying Physician:** To the best of my knowladga, death occurred at the tima, data and placa, and dua to tha causa(s) and mannar as stated. 2 [ ] **Medical Examiner:** On the basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and piece, and dua to the cause(s) and mannar stated.

29b. Signature and title of certifiar:

29c. Licansa number: D28339

29d. Data signed (Month, Day, Year): December 1, 1997

30. Name and address of person who complated causa of daath (Item 23a) (Type, Print): LINDA FRENCH 101 E WHEEL ROAD Bel Air, Md. 21015

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State Registrar

31. Data filed (Month, Day, Year): DEC 22 1997

32. Registrar's Signature:

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41256

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDWARD CHARLES WILSON, JR.

2. Date of Death: Month: Dec. Day: 23 Year: 1997

3. Time of Death: 4:10 P.M.

4a. Facility Name *(If not institution, give street and number)*: Lorien Nursing & Rehabilitation Center

4b. City, Town, or Location of Death: Belcamp

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 218-32-1650

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 90 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 9, 1907

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Darlington

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 2000 Glenville Road

10f. Zip Code: 21034

10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Lawyer

16b. Kind of Business/Industry: Legal

17. Father's Name *(First, Middle, Last)*: Edward Charles Wilson, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Virginia A. Jones

19a. Informant's Name/Relationship *(Type, Print)*: Margaret R. Wilson/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2000 Glenville Road, Darlington, MD 21034

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Darlington Cemetery

Date: 12/27/97

20c. Location - City or Town, State: Darlington, Maryland

21. Signature of Funeral Service Licensee: Stephen A Hughes

22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — 1 YEAR

Due to (or as a consequence of):

b. ISCHEMIC HEART DISEASE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Andrew Nowakowski MD

29c. License number: D08096

29d. Date signed *(Month, Day, Year)*: DECEMBER 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ANDREW NOWAKOWSKI MD 25 N. MAIN ST BEL AIR, MD 21014

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41257

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ESTHER R. WHITE

2. Date of Death Month: Dec. Day: 27 Year: 1997

3. Time of Death: 1:05 AM

4a. Facility Name *(If not institution, give street and number)*: Calvert Manor Healthcare Center

4b. City, Town, or Location of Death: Rising Sun

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 221106806

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 8, 1906

9. Birthplace *(State or Foreign Country)*: PA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Cecil

10c. City, Town or Location: 1881 Telegraph Rd. Rising Sun

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1881 Telegraph Rd.

10f. Zip Code: 21911

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Kennel Owner

16b. Kind of Business/Industry: Kennel

17. Father's Name *(First, Middle, Last)*: Charles Roye

18. Mother's Name *(First, Middle, Maiden Surname)*: Sara Smith

19a. Informant's Name/Relationship *(Type, Print)*: Roberta Johnson

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 21 South Fifth St. Oxford, PA 19363

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Oxford Cemetery

Date: Jan. 3, 1997

20c. Location - City or Town, State: Oxford, PA

21. Signature of Funeral Service Licensee: Kenneth D. Collins

22. Name and Address of Facility: Edward L. Collins Funeral Home 86 Pine St. Oxford, PA 19363

Physician /Medical Examiner

ETC

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause *on* each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. A.S.C.V.D. — 3 yrs

Due to (or as a consequence of): b. Congestive heart failure — 1 day

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c.

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Neil R Taylor MD

29c. License number: D-11115

29d. Date signed *(Month, Day, Year)*: 12-27-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Neil R. Taylor MD, Rising Sun, MD 21911

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 31 1997

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41258

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roy A Whitley

2. Date of Death: Month Dec Day 17 Year 1997

3. Time of Death: 11:20 p.m.

4a. Facility Name (If not institution, give street and number): Southern MARYLAND Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 303-03-6494

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 99 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 24, 1898

9. Birthplace (State or Foreign Country): Indiana

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince GEorge's

10c. City, Town or Location: Temple Hills

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 6404 Gifford Lane

10f. Zip Code: 20748

10g. Citizan of What Country? United States of America

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chemist

16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): William S. Whitley

18. Mother's Name (First, Middle, Maiden Sumame): Minnie C. Dewitt

19a. Informant's Name/Relationship (Type, Print): Richard A. Whitley/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 6404 Gifford Lane, Temple Hills, Maryland 20748

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other place): Forest Hill Cemetery

Date: December 22, 1997

20c. Location - City or Town, State: Greencastle, Indiana

21. Signature of Funeral Service Licensee #M00690: Howard Causan

22. Name and Address of Facility: G.H. Herrmann Funeral Home 5141 Madison Avenue, Indianapolis, Indiana 46227

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused tha death. Do not antar the mode of dytng, such es cerdiac or respiratory arrest, shock, or heart failura. List only ona causa on eech line.

Approximate Interval Between Onsat and Death

Immediate Ceuse (Finat disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE — 3 days.

Due to (or as a consequence of):

b. ATHEROSCEROTIC HEART DISEASE — More than 10 years.

Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as e consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

RENAL FAILURE

Aortic Stenosis

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medicat examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Restdence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medicel Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gyan chand Surana

29c. License number: D50653

29d. Date signed (Month, Day, Year): December 18, 1997

30. Name end address of person who completed ceuse of death (Item 23e) (Type, Print): GYAN CHAND SURANA. Suite 307. 7501 SURRATTS ROAD. CLINTON M.D

State Registrar

31. Date tiled (Month, Day, Yeer): DEC 23 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41259

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: Floyd Hall Warner

2. Deta of Death — Month: December; Dey: 21; Yeer: 1997

3. Time of Deeth: 2:10 pm

4e. Feciity Neme *(If not institution, give street end number)*: 1494 Harwell Ave.

4b. City, Town, or Locafion of Death: Crofton,

4c. County of Death: Anne Arundel

Funeral Director

5. Socie! Security Number: 212-44-8662

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. lest birthday)*: 87 Yrs.

If Undar 1 Year — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Dey, Year)*: Jan. 10, 1910

9. Birthplace *(Stete or Foreign Country)*: Massachusetts

Usuel Residenca of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Crofton

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 1494 Harwell Ave.

10f. Zip Code: 21114

10g. Citizen of Whet Country?: United States

11. Marital Stetus: 1 [ ] Never Merried 2 [X] Marriad 3 [ ] Widowed 4 [ ] Divorcad

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yas 2 [X] No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, atc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Reca - Amarican Indian, Bleck, White, etc. *Specify:* White

15. Decadent's Education *(Specify only highast grede completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+): 5+

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Associate Professor

16b. Kind of Business/Industry: U.S. Naval Academy

17. Father's Nema *(First, Middla, Last)*: Charles Warner

18. Mother's Neme *(First, Middle, Maiden Sumema)*: Elizabeth Hall

19a. Informent's Name/Reletionship *(Type, Print)*: David K. Warner (son)

19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Steta, Zip Code)*: 1494 Harwell Ave. Crofton, Md. 21114

20a. Method of Disposition: 1 [ ] Buriel 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Piece of Disposition *(Nema of cemetery, cremetory or othar place)*: Ft. Lincoln Crematory

Date: 12-23-97

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funaral Service Licensee: [signature]

22. Nama and Address of Feciity: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disaasa, or complications thet causad the death. Do not enter the mode of dying, such es cardiec or respiretory arreet, shock, or heert failure. List only one ceuse on eech line.

Approximate Interval Between Onset end Death

Immediete Cause (Finel disease or condition resulting in deeth) e. Metastatic prostate cancer — 2yrs

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initiatad events resulting in deeth) Last

b.

Due to (or es e consequenca of):

c.

Dua to (or as e consequence of):

d.

Part II. **Other significant conditiona** contributing to daath but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yee 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No

26. Piece of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Naturei 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rurel Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end pleca, and due to the cause(s) and menner as steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end manner stated.

29b. Signature and title of certifier: Peter Graze MD

29c. License number: D16364

29d. Date signed *(Month, Day, Year)*: 12/22/97

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): Peter R. Graze 900 Bestgate Rd Suite 300 Annapolis md 21401

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed *(Month, Dey, Year)*: DEC 23 1997

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

97-7333-510
AM
ROBERT
BOWEN

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41260

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Robert Bowen
2. Date of Death (Month, Day, Year): DECEMBER 19, 1997
3. Time of Death: 2000 P
4a. Facility Name (If not institution, give street and number): 935 ST. PAUL ST. APT# 1R
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: unknown
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 54 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 23, 1943
9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 935 St. Paul Street
10f. Zip Code: 21202
10g. Citizen of What Country? unknown

11. Marital Status: unknown — 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? unknown — 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) — 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Pat Connley/sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify): in state
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? pathol — 1 ☑ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and ~~title of~~ certifier
29c. License number: OCME
29d. Date signed (Month, Day, Year): DECEMBER 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 15 1998
~~32.~~ Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-7485-510
B.K.S
ALEXANDER CERES

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41261

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Alexander Ceres
2. Date of Death — Month: DEC. Day: 26, Year: 1997
3. Time of Death: 1430 PM
4a. Facility Name *(If not institution, give street and number)*: 110 CROSS KEYS APT. #A
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: unknown
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 61 Yrs.
If Under 1 Year — Months: Days:
If Under 24 Hrs. — Hours: Min.:
8. Date of Birth *(Month, Day, Year)*: Feb. 15, 1936
9. Birthplace *(State or Foreign Country)*: unknown

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 110 Cross Keys Apt. A
10f. Zip Code: 21210
10g. Citizen of What Country?: unknown

11. Marital Status: unknown — 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? unknown — 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) — 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): unknown — College (1-4or 5+): unknown
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unknown
16b. Kind of Business/Industry: unknown

17. Father's Name *(First, Middle, Last)*: unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: unknown

19a. Informant's Name/Relationship *(Type, Print)*: unknown
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: unknown

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other *(Specify)* in state
20b. Place of Disposition *(Name of cemetary, crematory or other place)*
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Atherosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? Inspection — 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☒ Yes 2 ☐ No
26. Place of Death *(Check only one)* — Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*
1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Stephen S. Radentz, MD
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Year)*: DEC. 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 15 1998
32. Registrar's Signature

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

JAN 1 6 1958

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41262

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FERMILLA COLLIER

2. Date of Death Month Dey Yaar: December 29, 1997

3. Time of Death: 10:29pm

4a. Facility Name *(If not institution, giva street and number)*: Washington Adventis Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-21-8934

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 38 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: May 3, 1959

9. Birthplaca *(Stata or Foreign Country)*: unknown

Usual Rasidance of Dacedant

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6500 Riggs Road

10f. Zip Coda: 20783

10g. Citizan of What Country?: U.S.A.

11. Meritei Status: unknown
1☐ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Dacedent Ever in U.S. Armed Forcas? unknown
1☐ Yes 2☐ No
If Yas, Giva Yeer or Detes:

13. Wes Decedant of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.)
1☐ Yas 2☒ No *Specify:*

14. Rece - American Indian, Black, White, etc.
Specify: Black

15. Dacedant's Education *(Specify only highest grade compleated)*
Elementary/Secondary (0-12): unknown
College (1-4or 5+): unknown

16a. Dacedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use retired)*: unknown

16b. Kind of Businass/Industry: unknown

17. Father's Nama *(First, Middla, Last)*: unknown

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: unknown

19a. Informant's Name/Relationship *(Type, Print)*: unknown

19b. Mailing Address *(Streat and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: unknown

20a. Method of Disposition
1☐ Burial 2☐ Cremetion 3☐ Ramoval from Stata
4☐ Donation 5☒ Other *(Specify)* in state

20b. Piece of Disposition *(Nama of cematary, cramatory or other placa)*

Data

20c. Location - City or Town, Stata

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part1. Entar the disaasa, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only one causa on aach lina.

Approximate Intarval Batween Onset and Daath

Immadiata Cause (Final disaasa or condition rasulting in death)
a. Respiratory failure — few days

Dua to (or as a consequence of):
b. Bilateral Pneumonia

Sequentially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Diseasa or injury that initiated evants rasulting in daath) Last

Dua to (or as a consequanca of):
c.

Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Metastatic adenocarcinoma of skull
Sick - Sinus Syndrome
HIV Positive status

23b. Did tobacco use contribute to the cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?
1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to compliation of causa of daath?
1☐ Yas 2☐ No

25. Was casa rafarred to medical examiner?
1☐ Yas 2☒ No

26. Placa of Death *(Check only one)*
Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA
Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death
1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At homa, farm, straat, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*
1☒ **Certifying Physician:** To tha best of my knowledge, death occurred at tha time, date and place, and due to the causa(s) and mannar as statad.
2☐ **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and mannar stated.

29b. Signatura and title of certifier: G. Gupta MD

29c. License number: D 46398

29d. Dete signed *(Month, Day, Year)*: December 30, 1997

30. Nama and addrass of parson who completed causa of death (Item 23a) (Type, Print): G. Gupta, MD, 121 congressional Lane, # 409, Rockville, MD 20852

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 15 1998

32. Registrar's Signatura: Julie Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

97-7084-015
AM
VIRGIL
KINNAMON

Film G756 Item 23 Part i 27,28a-f 2-14-98 Per ME

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41263

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Virgil N. Kinnamon
2. Data of Death Month Day Yeer: DECEMBER 08,1997
3. Time of Death: 07:43 A
4e. Facility Neme *(If not institution, give streat and number)*: LOT #29 INDIAN ACRES
4b. City, Town, or Location of Deeth: Georgetown
4c. County of Death: CECIL

Funeral Director

5. Social Security Number: unknown
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 42 Yrs. | If Under 1 Yaer Months Deys | If Undar 24 Hrs. Hours Min.
8. Dete of Birth *(Month, Dey, Yeer)*: June 29, 1955
9. Birthplece *(Stete or Foreign Country)*: Delaware

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Cecil
10c. City, Town or Location: Georgetown
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: Glen 2, Lot #29 Indian Acres
10f. Zip Code: 21930
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: unknown — 1☐Nevar Married 2☐Married 3☐Widowad 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forcas? 1☐Yes 2☒No If Yas, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grade completed)*: Elementery/Secondery (0-12): unknown; College (1-4or 5+): unknown
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Mechanic
16b. Kind of Business/Industry: Auto Shop

17. Fether's Neme *(First, Middle, Last)*: Marion Kuligowski
18. Mother's Neme *(First, Middle, Maiden Sumema)*: June M. Anakarico

19e. Informent's Name/Relationship *(Type, Print)*: Marion Kuligowski, Jr./brother
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, State, Zip Code)*: unknown

20a. Method of Disposition: 1☐Burial 2☐Cremetion 3☐Removel from State 4☐Donetion 5☒Other *(Specify)* in state
20b. Piece of Disposition *(Neme of cemetery, cremetory or other place)*
Dete
20c. Location - City or Town, State

21. Signeture of Funerel Service Licensee: Ronald S. Wade, Director
22. Neme and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet caused the deelh. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one cause on eech line.

Approximete Interval Between Onset end Deelh

Immediete Ceuse (Final diseese or condition resulting in daath)
e. NARCOTIC AND COCAINE INTOXICATION

Due to (or es e consequenca of):

Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest
b.
Due to (or es e consequenca of):
c.
Due to (or es e consequenca of):
d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☑Unknown

24e. Wes en eutopsy performed? 1☑Yes 2☐No
24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☑Yes 2☐No

25. Wes case referred to medical exeminer? 1☒Yes 2☐No

26. Place of Death *(Check only one)*
Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA
Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Menner of Deeth: 1☐Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☑Pending investigation XX☐Could not be determined
28e. Dete of Injury *(Month, Dey Yeer)*: Found 12-8-97
28b. Time of Injury: 7:15 A M
28c. Injury et Work? 1☐Yes 2☒No
28d. Describe how injury occurred: UNKNOWN
28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. *(Specify)*: FOUND RESIDENCE
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*: Glen 2 Lot 29 Indian Acres Georgetown MD.

29e. Certifier *(Check only one)*: 1☐**Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the cause(s) end menner es steted. 2☒**Medical Examiner:** On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end mannar stated.

29b. Signeture and title of certifier
29c. License number: OCME
29d. Data signed *(Month, Dey, Year)*: DECEMBER 09,1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): MARYANNA K. KOWER 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dele filed *(Month, Day, Yeer)*: JAN 15 1998
32. Registrer's Signeture: Julie Davidson-Ramballi

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41264

Physician /Medical Examiner

1. Decedant's Name *(First, Middle, Last)*: Billy James KnoBlock

2. Data of Death Month: Dec Day: 27 Year: 97

3. Time of Death: 3:05 PM

4a. Facility Name *(If not institution, give street and number)*: 4506 Gladwyn Drive

4b. City, Town, or Location of Daath: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 453-44-5245

6. Sax: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 66 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Dec. 6, 1931

9. Birthplaca *(State or Foreign Country)*: unknown

Usual Rasidence of Decedent

10a. Stata: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 4506 Gladwyn Drive

10f. Zip Code: 20814

10g. Citizen of What Country?: U.S.A.

11. Marital Status: unknown
1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? unknown
1☐ Yas 2☐ No
If Yes, Giva Yaar or Dates:

13. Was Dacedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedant's Education *(Specify only highast grade completed)*
Elementary/Secondary (0-12): unknown
Collage (1-4or 5+): unknown

16a. Dacedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use ratired)*: unknown

16b. Kind of Business/Industry: unknown

17. Father's Name *(First, Middla, Last)*: unknown

18. Mother's Name *(First, Middla, Maiden Surname)*: unknown

19a. Informant'a Name/Relationship *(Type, Print)*: unknown

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Coda)*: unknown

20a. Method of Disposition
1☐ Burial 2☐ Cremation 3☐ Ramoval from State
4☐ Donation 5☒ Other *(Specify)* in state

20b. Place of Disposition *(Name of cemetery, cramatory or other place)*

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha death. Do not entar the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only one cause on each lina.

Approximata Interval Batween Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Heart Disease 4 years

Due to (or as a consequance of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?**
1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed?
1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to complation of causa of daath?
1☐ Yes 2☒ No

25. Was case rafarred to medical examiner?
1☒ Yes 2☐ No

26. Place of Death *(Check only one)*
Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Homa 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death
1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending investigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*
1☐ **Certifying Physician:** To tha best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, date and place, and due to tha cause(s) and mannar stated.

29b. Signature and fitla of certifier: John Tandler MD

29c. License number: D08546

29d. Date signed *(Month, Day, Year)*: Dec 27 1997

30. Nama and address of person who complated causa of daath (Item 23a) (Type, Print): John Tandler 8218 Wisconsin Ave Bethesda MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 15 1998

32. Registrar's Signature: Julia Davidson-Randolph

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: Tha law requires that the death certificata be axecuted within 24 hours after death.
To the Funeral Director: After this cartificata has been signed by tha attanding physician and completely filled in by the funaral director, paga 2 should be datached for usa as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

97-7146-510
AM
HARRISON
LEWIS JR.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene — Item: 10f Per MEO Film G-755 1-15-98RC

Certificate of Death

97 41265
Reg. No.

Physician /Medical Examiner | **Funeral Director**

1. Decedent's Name (First, Middle, Last): Harrison Lewis, Jr.
2. Date of Death (Month, Day, Year): DECEMBER 11, 1997
3. Time of Death: 7:55 P
4a. Facility Name (If not institution, give street and number): 1107 HORNERS LANE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:
5. Social Security Number: unknown
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 60 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 30, 1937
9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1101 Horners Lane
10f. Zip Code: ~~21215~~ 21205
10g. Citizen of What Country? U.S.A.
11. Marital Status: unknown — 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): unknown — College (1-4 or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: unknown
17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): unknown
19a. Informant's Name/Relationship (Type, Print): unknown
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Gastrointestinal Hemorrhage
Due to (or as a consequence of):
b. Chronic Alcoholism

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one) — Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: OCME
29d. Date signed (Month, Day, Year): DECEMBER 12, 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): J. AARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 15 1998
32. Registrar's Signature:

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41266

Carl Morris

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Carl Roderick Morris

2. Date of Death Month: Dec. Day: 22, Year: 1997

3. Time of Death: 6:36 am

4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital at Easton

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 393-32-1081

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 24, 1939

9. Birthplace *(State or Foreign Country)*: Wisconsin

Usual Residence of Decedent

10a. State: N.Carolina | 10b. County: Wake | 10c. City, Town or Location: Morrisville | 10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1512 Wackena Road | 10f. Zip Code: 27560 | 10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Scientist

16b. Kind of Business/Industry: Tolicology

17. Father's Name *(First, Middle, Last)*: Ervin Edward Morris

18. Mother's Name *(First, Middle, Maiden Surname)*: Dottie Mae Remington

19a. Informant's Name/Relationship *(Type, Print)*: Louise B. Morris/wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1512 Wackena Road, Morrisville, North Carolina 27560

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)* | Date | 20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade Director — Ronald S. Wade

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Hypertensive and arteriosclerotic cardiovascular dis. — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Unexplained anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David A. Stout, M.D. | 29c. License number: D06804 | 29d. Date signed *(Month, Day, Year)*: 12/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Allan Stout, M.D. 219 S. Washinton St. Easton, MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 15 1998

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indellble Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41267

Physician /Medical Examiner

1. Decedent's Nama *(First, Middla, Last)*: Ruthena Warren Tudbury

2. Data of Daath — Month: December — Day: 26 — Yaar: 1997

3. Tima of Death: 4:00AM

4a. Facility Nama *(If not institution, giva street and number)*: 3000 N. Ridge Road

4b. City, Town, or Location of Death: Ellicott City

4c. County of Death: Howard

Funeral Director

5. Social Sacurity Numbar: 286-32-5728

6. Sax: 1☐M 2☒F

7. Aga *(In yrs. last birthday)*: 87 Yrs.

If Undar 1 Yaar — Months: Days:

If Undar 24 Hrs. — Hours: Min.:

8. Data of Birth *(Month, Day, Yaar)*: April 12, 1910

9. Birthplaca *(Stata or Foraign Country)*: Massachusetts

Usual Rasidanca of Decadant

10a. Stata: Maryland

10b. County: Howard

10c. City, Town or Location: Ellicott City

10d. Inside City Limits: 1☐Yas 2☒No

10e. Street and Number: 3000 N. Ridge Road

10f. Zip Coda: 21043

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐Navar Marriad 2☒Marriad 3☐Widowad 4☐Divorcad

12. Was Decadant Evar in U.S. Armad Forcas? 1☐Yas 2☒No If Yas, Giva Yaar or Datas:

13. Was Decadant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐Yas 2☒No *Specify:*

14. Raca - Amarican Indian, Black, White, atc. *Specify:* White

15. Decadant's Education *(Spacify only highast grada compiatad)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decadent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retirad)*: Homemaker

16b. Kind of Businass/Industry: Own Home

17. Fathar's Nama *(First, Middla, Last)*: Frank Densmore Warren

18. Mother's Nama *(First, Middla, Maidan Sumama)*: Ruthena Morrison

19a. Informant's Nama/Ralationship *(Type, Print)*: Martha T. Hamill/daughter

19b. Mailing Address *(Straat and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 8622 Hay Shed Lane, Columbia, Maryland 21045

20a. Mathod of Disposition: 1☐Burial 2☐Cramation 3☐Ramoval from Stata 4☒Donation 5☐Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*

Data:

20c. Location - City or Town, Stata

21. Signatura of Funaral Sarvica Licansaa: Ronald S. Wade, Director

22. Nama and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that causad tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach line.

Approximata Intarval Batwaan Onsat and Death

Immadiata Causa (Final disaasa or condition resulting in daath)

a. Respiratory failure — 2 days

Due to (or as a consaquanca of):

b. Possible Pneumonia.

Saquantially list conditions, if any, leading to immadiata causa. Enter Undarlying Causa (Diseasa or Injury that Initiatad avants rasulting in daath) Last

Due to (or as a consaquanca of):

c.

Due to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

Coronary artery disease

Stroke

Degenerative Joint Disease

23b. Did tobacco usa contribute to the cause of death? 1☐Yas 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Ware autopsy findings available prior to compiation of causa of death? 1☐Yas 2☐No

25. Was casa rafarrad to medical examinar? 1☐Yas 2☒No

26. Placa of Death *(Check only ona)*: Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA; Othar: 4☒Nursing Homa 5☐Rasidance 6☐Othar *(Specify)*

27. Mannar of Death: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding invastigation 6☐Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascribe how injury occurred

28e. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Spacify)*

28f. Location *(Straat and Numbar or Rurel Routa Numbar, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒**Cartifying Physician:** To tha bast of my knowladga, daath occurrad at the time, data and placa, and dua to tha causa(s) and mannar as stated. 2☐**Medical Examinar:** On the basis of axamination and/or invastigation, in my opinion, daath occurrad at tha time, data and placa, and dua to the cause(s) and mannar stated.

29b. Signatura and titla of cartifiar: [illegible]

29c. Licansa number: D31927

29d. Data signed *(Month, Day, Yaar)*: 12-29-97

30. Nama and address of parson who completed cause of death (Item 23a) (Type, Print): HO-LAI FENG, MD Two Knoll North Dr. Columbia. MD 21045

State Registrar

31. Data filed *(Month, Day, Yaar)*: JAN 15 1998

32. Registrar's Signatura: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97-7517-035

-B.K.S

ANN VAUGHAN Items:23a ppart I,27,28a-f per MEO G-755 1/17/98 db

Items: 10bce Per MEO Film G-755 1-15-98RC

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41268

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
Ann	Vaughan		DEC. 28, 1997	0610 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
5428 OLD CRAIN HIGHWAY	UPPER MARLBORO	PRINCE GEORGES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
unknown	1☐ M 2☒ F	43 Yrs.			July 15, 1954	unknown

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	PRINCE Georges ~~Anne Arundel~~	Upper Marlboro ~~Shady Side~~	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
~~6285~~ 5428 Old Crain Highway	20772	unknown

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	unknown 1☐ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
unknown	unknown	unknown	unknown

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
unknown	unknown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Tom Commander/brother	7103 Norwalk Street, Falls Church, Virginia 22403

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ronald S. Wade, Director	State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. MIXED DRUG INTOXICATION	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown	1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined	12/28/97	5:45 A M	1☐ Yes 2☒ No	subject ingested drugs

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
home	5428 Old Crain Highway, Upper Marlboro, Md.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Stephen S. Radentz, MD	O.C.M.E	DEC. 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 15 1998	

DHMH 16 Rev 6/95

97-7494-510

ROSETTA

WILLIAMS

Items:23a part I,II,27 per MEO G-755 1/21/98 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41269

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Rosetta Williams	DECEMBER 26, 1997	23:24 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MARYLAND GENERAL HOSPITAL	BALTIMORE	Baltimore City

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
unknown	1☐ M 2☒ F	47 Yrs.			April 10, 1950	unknown

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore City	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
125 Colvin Street	21202	unknown

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
unknown 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	unknown 1☐ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
unknown	unknown	unknown	unknown

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
unknown	unknown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
unknown	unknown

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ronald S. Wade, Director	State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MYOCARDITIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CELLULITIS

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
J. Aaron Locke MD	OCME	DECEMBER 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
J. AARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 15 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

97-7341-510
AYDELETTE
ZORNAK
Item:10f Per MEO Film G-756 2-2-98RC
Items:23a part I,27,28a-f per MEO G-755 1/17/98 dh

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41270

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Aydelette Zornak

2. Date of Death Month Day Year: DECEMBER 20, 1997

3. Time of Death: 01:10 AM

4e. Facility Name *(If not Institution, give street and number)*: 1818 WILKINS AVENUE

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: unknown

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 28, 1928

9. Birthplace *(State or Foreign Country)*: unknown

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1818 Wilkins Avenue

10f. Zip Code: ~~21233~~ 21223

10g. Citizen of What Country?: U.S.A.

11. Marital Status: unknown
1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? unknown
1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc.
Specify: White

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): unknown
College (1-4or 5+): unknown

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unknown

16b. Kind of Business/Industry: unknown

17. Father's Name *(First, Middle, Last)*: unknown

18. Mother's Name *(First, Middle, Maiden Surname)*: unknown

19a. Informant's Name/Relationship *(Type, Print)*: Adam Zornak/son

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: unknown

20a. Method of Disposition
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other *(Specify)* in state

20b. Place of Disposition *(Name of cemetery, crematory or other place)*

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade/ Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. SMOKE INHALATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?
1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No

25. Was case referred to medical examiner?
1☒ Yes 2☐ No

26. Place of Death *(Check only one)*
Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*: 12/20/97

28b. Time of Injury: 12:59 A M

28c. Injury at Work?
1☐ Yes 2☒ No

28d. Describe how injury occurred: house fire

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: home

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 1818 Wilkins Avenue, Baltimore City, Md.

29a. Certifier *(Check only one)*
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: OCME

29d. Date signed *(Month, Day, Year)*: DECEMBER 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
~~111 Penn Street, Baltimore, Maryland 21201~~

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 15 1998

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Item:8 per FH G-755 1/17/98 dh

Reg. No. 97 41271

Name: Arthur Franklin Ahalt

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Arthur Franklin Ahalt

2. Date of Death (Month, Day, Year): December 18, 1997

3. Time of Death: 5:32 PM

4a. Facility Name (If not Institution, give street and number): Reeders Memorial Home

4b. City, Town, or Location of Death: Boonsboro

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 216-14-6830

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): ~~Feb. 9 1922~~ 2/9/22

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Boonsboro

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 7814 Sharpsburg Pike

10f. Zip Code: 21713

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: W.W.II

13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - Americen Indian, Black, White, atc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed)

Elementery/Secondery (0-12): 11

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Production/Management

16b. Kind of Business/Industry: Aircraft

17. Father's Name (First, Middle, Last): Leon Franklin Ahalt

18. Mother's Name (First, Middle, Maiden Sumeme): Ida F. Price

19a. Informant's Name/Relationship (Type, Print): Mary Jane Ahalt

19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code): 7814 Sharpsburg Pike Boonsboro, Md. 21713

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Rocky Gap Vet. Cemetery

Data: 12/22/97

20c. Location - City or Town, State: Flinstone, Md.

21. Signature of Funeral Service Licensee: Fred L Wentz

22. Name and Address of Facility: Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter tha disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION — 2 HRS

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE — UNKNOWN

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. ARTERIOSCLEROSIS — UNKNOWN

Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not rasulting in the underlying ceuse given in Part I.

CONGESTIVE HEART FAILURE

CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to complation of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Wes cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one)

Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Othar (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifiar

29c. License number: D44996

29d. Date signed (Month, Day, Year): December 19, 1997.

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print): Dr. Zafar Malik 20311 Lappans Road, Boonsboro, Maryland 21713/301-432-8470

State Registrar

31. Data filed (Month, Day, Year): DEC 19 1997

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attanding Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41272

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SADIE GRACE ASHBY

2. Date of Death Month / Day / Year: NOV. 15, 1997

3. Time of Death: 1:30 P.M.

4a. Facility Name *(If not institution, give street and number)*: ROCK GLEN NURSING HOME

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-24-1635

6. Sex: 1☐ M 2☒ F

7. Age *(in yrs. last birthday)*: 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN 3, 1931

9. Birthplace *(State or Foreign Country)*: MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3611 MARY AVE.

10f. Zip Code: 21206

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LABORER

18b. Kind of Business/Industry: FACTORY

17. Father's Name *(First, Middle, Last)*: VINCENT D'ANGLO

18. Mother's Name *(First, Middle, Maiden Surname)*: NANCY UNKNOWN

19a. Informant's Name/Relationship *(Type, Print)*: COM. ON AGING MRS. HAMILTON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 861 PARK AVE. BALTO. MD. 21201

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: VOSHELLS CEM.

Date: NOV. 22 1997

20c. Location - City or Town, State: BALTO. MD.

21. Signature of Funeral Service Licensee: Thomas J. Skarda Jr.

22. Name and Address of Facility: SKARDA FH. 2829 HUDSON ST. BALTO. MD. 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung cancer

Due to (or as a consequence of): b. Hypertension

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. Pneumonia

Due to (or as a consequence of): d. cardio-pulmonary arrest

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D30115

29d. Date signed *(Month, Day, Year)*: 1/14/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): T. OMIOKPEHAI MD 3600 LIBERTY HGT AVE BALTIMORE MD 21215

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 16 1998

32. [illegible] Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 1 Per PHY Film G755 1-16-98 rja

Certificate of Death

Reg. No. 97 41273

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ralph June Brooks Jr.
2. Deta of Deeth — Month: December Dey: 18, Yeer: 1997
3. Time of Death: 0700
4e. Facility Nema (If not institution, give street end number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE CITY
4c. County of Death: BALTIMORE CITY

Funeral Director

5. Social Security Numbar: 489-32-6461
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 66 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): August 18, 1931
9. Birthplace (Stete or Foraign Country): Springfield, Missouri

Usuel Residence of Decedent

10a. Stata: PA
10b. County: York
10c. City, Town or Location: York Haven
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 95 South Landvale
10f. Zip Code: 17370
10g. Citizen of Whet Country?: US

11. Merital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grede completed) — Elementery/Secondery (0-12): 12 — Colliege (1-4or 5+): 4
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Executive
16b. Kind of Business/Industry: Department Store
17. Fether's Nema (First, Middle, Last): Ralph J. Brooks, Sr.
18. Mother's Name (First, Middle, Meiden Sumeme): Lillian I. [McLaughlin] Brooks
19a. Informent's Neme/Retetionship (Type, Print): Charlotte J. Brooks/wife
19b. Meiting Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 95 South Landvale, York Haven, PA 17370
20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [X] Ramoval from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Mount Rose Cemetery
Date: Dec. 22, 1997
20c. Location - City or Town, Stete: York, Pennsylvania
21. Signature of Funeral Service Licensee: Todd E. Little
22. Neme end Address of Fecility: William E. Little Funeral Home, Inc. 60 South Main Street, Manchester, PA 17345

Physician /Medical Examiner

23e. Pert1. Entar the diseesa, or complications thet caused the death. Do not anter the mode of dying, such es cardiac or respiretory arrest, shock, or heert failure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Finel diseese or condition resulting in deeth) e.	bacterial endocarditis	1 week
Due to (or es e consequence of):		
Sequentiellty list conditions, if eny, leeding to Immediete cause. Enter Underlying Cause (Diseese or Injury thet Initieted events resulting in deeth) Lest b.	aortic stenosis	5 years
Due to (or es e consequence of):		
c.	coronary arteny stenosis	20 years
Due to (or es e consequenca of):		
d.		

Part II. **Other significant conditiona** contributing to death but not rasulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availeble prior to complation of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Piece of Deeth (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Deeth: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Phyaictan:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner as steted. 2 [ ] **Medical Examiner:** On the basis of examinetion end/or Invastigetion, In my opinion, deeth occurred et the time, date end piaca, end due to the cause(s) and manner steted.

29b. Signature end title of certifier: Steven Cohn MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): December 18, 1997

30. Nema and address of person who completed cause ot deeth (Item 23e) (Type, Print): Johns Hopkins Hospital, Baltimore, Maryland

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 16 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41274

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Lest): Elvira S. Demejia

2. Dete of Deeth — Month: July; Dey: 11; Yeer: 1997

3. Time of Death: 12:15 AM

4e. Feclity Neme (If not Institution, give street end number): I-95 South

4b. City, Town, or Locetion of Death: Riverside

4c. County of Deeth: Harford

Funeral Director

5. Social Security Number: N/A

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. lest birthdey): 57 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): Dec. 20, 1939

9. Birthplece (Stete or Foreign Country): Mexico

Usuel Residence of Decedent

10a. State: NY

10b. County: Queens

10c. City, Town or Locetion: Flushing

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 47-11 160th Street

10f. Zip Code: N/A

10g. Citizen of Whet Country?: USA

11. Merital Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1☒ Yes 2☐ No Specify: Mexican

14. Rece - Americen Indien, Bleck, White, etc. Specify: Mexican

15. Decedent's Education (Specify only highest grede completed) — Elementery/Secondery (0-12): 12th Grade — College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: N/A

17. Fether's Neme (First, Middle, Lest): Leopoldo Soriano

18. Mother's Neme (First, Middle, Meiden Surneme): Telesfora Aguirre

19a. Informent's Neme/Relationship (Type, Print): Florencio M. Mejia

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1 Post Street, Yonkers, NY 10705

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other piece): Cemeterio Municipal

Date: 07/17/97

20c. Locetion - City or Town, Stete: Mexico City

21. Signeture of Funerel Service Licensee: Willie E. Hardy Jr.

22. Neme end Address of Facility: Unity Funeral Home - 108 W. North Avenue Baltimore, MD 21201 - (410) 752-4941

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximate Interval Between Onset end Deeth

Immediate Ceuse (Final disease or condition resulting in death): e. Multiple Injuries

Due to (or es e consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initieted events resulting in death) Lest

b. Due to (or as e consequenca of):

c. Due to (or es e consequenca of):

d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Deeth (Check only one) — Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☒ Other (Specify): Roadway

27. Manner of Deeth: 1☐ Netural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Dete of Injury (Month, Dey Yeer): July 10, 1997

28b. Time of Injury: 11:15P

28c. Injury et Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: Passenger in Auto Accident

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Highway

28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete): I-95 South

29a. Certifier (Check only one) — 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es stated. 2☒ **Medical Examiner**: On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier: Laron Locke MD

29c. License number: O.C.M.E.

29d. Dete signed (Month, Dey, Yeer): July 11, 1997

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): Laron Locke, MD 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 16 1998

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the deeth certificate be executed within 24 hours efter deeth.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Items:1,25,26 per MD G-755 1/17/98 dh

Reg. No. 97 41275

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Macy ~~RUTH~~ ~~MACY~~

2. Date of Death: Month DEC Day 08 Year 97

3. Time of Death: 0020 AM

4a. Facility Name (If not Institution, give street and number): GOOD SAMARITAN HOSPITAL OF MARYLAND

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 479-22-3307

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 79 Yrs.

If Under 1 Year: Months ___ Days ___

If Under 24 Hrs.: Hours ___ Min. ___

8. Date of Birth (Month, Day, Year): Oct. 18, 1918

9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6401 Loch Raven Boulevard

10f. Zip Code: 21239

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? unknown 1☐ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): unknown

College (1-4or 5+): unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown

16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, cremetory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. GASTROINTESTINAL BLEED. few hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COAGULOPATHY

END STAGE RENAL DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Maurice Bachawati, MD

29c. License number: P 11399

29d. Date signed (Month, Day, Year): DEC 08 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MAURICE BACHAWATI THE GOOD SAMARITAN HOSPITAL OF MARYLAND, 5601 LOCH RAVEN BLVD BALTIMORE MD 21239

State Registrar

31. Date filed (Month, Day, Year): JAN 16 1998

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 15b Per PH Film G755 1-16-98 rja
Item 3 Per Phy Film G755 1-16-98

Certificate of Death

Reg. No. 97 41276

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY ROBINSON

2. Date of Death: Month Nov. Dey 1 Yeer 1997

3. Time of Death: 9:40 PM

4a. Facility Nema (If not institution, giva street end number): Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Maryland

Funeral Director

5. Social Security Number: 577-30-8114

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Dey, Yeer): 08 22 1919

9. Birthplece (Steta or Foraign Country): Orange

Usual Residenca of Decedent

10e. Stete: D.C.

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 5417 5th

10f. Zip Code: 20011

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Dacedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Datas:

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuben, Mexican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16e. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired): Government

16b. Kind of Business/Industry: SECRETARY

17. Father's Nama (First, Middle, Last): Clifford Chandler

18. Mother's Name (First, Middle, Meiden Surneme): Celia Thurston

19e. Interment's Name/Relationship (Type, Print): Gladys Harrison

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 1441 U St. Washington, D.C. 20009

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Westview Cemetery

Dete: 11/8/97

20c. Location - City or Town, Stete: Orange, Virginia 22960

21. Signeture of Funeral Service Licensee: [signature]

22. Name end Address of Facility: Satchells Funeral Service, Inc. 118 E. Church St. Orange, Va.

Physician /Medical Examiner

23e. Part I. Enter the disease, or complicetions thet caused the death. Do not enter the mode ot dying, such es cardiac or respiretory arrest, shock, or heert failure. List only one ceusa on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Finel diseese or condition resulting in deeth): e. Cerebro Vascular Accident — 30days

Due to (or es e consequence ot):

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in deeth) Last:

b.

Due to (or es e consequenca of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying cause given in Part I.: Alzheimer's Disease. Parkinsonism

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy tindings aveileble prior to compiation of causa of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

28. Ptece of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Pleca ot Injury - At home, ferm, streat, tectory, offica building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end pieca, and due to the cause(s) end menner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, dete end pieca, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier: [signature] MD

29c. Licensa number: 042580

29d. Data signed (Month, Dey, Yeer): 11/02/97

30. Nema and address of person who completed cause of deeth (Item 23e) (Type, Print): PS AMRA MD 5632 Annapolis Rd #13 Bladensburg MD 20710

State Registrar

31. Dete tiled (Month, Dey, Yeer): JAN 16 1998

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriel-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41277

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): KEMP, ANDREW

2. Date of Death Month Day Year: December 17, 1997

3. Time of Death: 10:14am

4a. Facility Name (If not institution, give street and number): NORTH ARUNDEL HOSPITAL

4b. City, Town, or Location of Death: GLEN BURNIE

4c. County of Death: A.A. COUNTY

Funeral Director

5. Social Security Number: 425-20-3014

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB. 9 1923

9. Birthplace (State or Foreign Country): MISSISSIPPI

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: MILLERSVILLE

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: P.O. BOX 302

10f. Zip Code: 21108

10g. Citizen of What Country?: US

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Yeer or Dates: W.W.II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puerto Ricen, etc.) 1☐Yes 2☒No Specify:

14. Race - Amaricen Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th

College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ELECTRICIAN

16b. Kind of Business/Industry: FT. GEORGE MEADE

17. Father's Name (First, Middle, Last): IRA KEMP

18. Mother's Neme (First, Middle, Maiden Surname): FRANCES BROWN

19a. Informent's Name/Relationship (Type, Print): BOBBY KEMP (SON)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): P.O. BOX 301 MILLERSVILLE, MD. 21108

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from Stete 4☐Donation 5☐Othar (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MARYLAND VETERAN CEMETERY

Date: 12/22/97

20c. Location - City or Town, State: CROWNSVILLE, MD.

21. Signature of Funeral Service Licensee: ▶ Harry D. Reese

22. Nama and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediete Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure — Years

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to immedieta cause. Enter Underlying Ceuse (Diseese or injury thet initieted events rasulting in deeth) Last

b. ____

Due to (or as a consequence of):

c. ____

Due to (or es a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Wes en autopsy performed? 1☐Yes 2☑No

24b. Were autopsy findings available prior to completion of causa of death? 1☐Yes 2☐No

25. Wes cese referred to medical examiner? 1☐Yes 2☑No

26. Piece of Death (Check only one): Hospital: 1☐Inpatiant 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☑Residence 6☐Other (Specify)

27. Manner of Deeth: 1☑Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Phyeician:** To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and manner as steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: ▶ Steph Gottlieb MD

29c. License number: D-36885

29d. Date signed (Month, Day, Year): 12/18/97

30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print): Stephen Gottlieb, MD 22 S. Greene St Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year): DEC 22 1997

32. Registrar's Signeture: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 4 1278

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ALKAY LOUISE BANKS

2. Date of Death: Month DEC Day 31 Year 1997

3. Time of Death: 1:24 P.M.

4a. Facility Name (If not institution, give street and number): ATLANTIC GENERAL HOSPITAL

4b. City, Town, or Location of Death: BERLIN

4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 222-24-1612

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 6-3-1942

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: DELAWARE

10b. County: SUSSEX

10c. City, Town or Location: FRANKFORD

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: HONOLULU ROAD

10f. Zip Code: 19945

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SCHOOL TEACHER

16b. Kind of Business/Industry: EDUCATION

17. Father's Name (First, Middle, Last): ELMER CANNON

18. Mother's Name (First, Middle, Maiden Surname): EVELYN A. PALMER

19a. Informant's Name/Relationship (Type, Print): ALKAY JUANITA BANKS/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): HONOLULU ROAD, FRANKFORD, DE. 19945

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MACEDONIA CEMETERY

Date: 1-3-98

20c. Location - City or Town, State: SEAFORD, DELAWARE

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: MELSON FUNERAL SERVICES FRANKFORD, DELAWARE 19945

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. CARDIAC ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

c. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

d. DIABETES

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gaudet MD

29c. License number: MD35461

29d. Date signed (Month, Day, Year): DEC 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ROBERT GAUDET, M.D. ATLANTIC GENERAL HOSPITAL

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12

VOID

CERTIFICATE #

97-41279

SEE

CERTIFICATE #

98-cert

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41280

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Lee Dennis
2. Date of Death: Month 12 Dey 28 Year 97
3. Time of Death: 17 00
4a. Facility Name (If not institution, give street and number): Home 1758 SAND PIT Rd
4b. City, Town, or Location of Death: Pocomoke
4c. County of Death: WORcester

Funeral Director

5. Social Security Number: 218-34-9714
6. Sex: 1 X M 2 ☐ F
7. Age (In yrs. last birthday): 59 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): 12-18 38
9. Birthplace (State or Foreign Country): maryland

Usual Residence of Decedent

10a. State: md
10b. County: WORcester
10c. City, Town or Location: Pocomoke City
10d. Inside City Limits: 1 ☐ Yes 2 X No
10e. Street and Number: 1758 SAND PIT Rd
10f. Zip Code: 21851
10g. Citizan of What Country? United States

11. Marital Status: 1 ☐ Nevar Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLK

15. Decedant's Education (Specify only highest grade completed)
Elamantary/Secondary (0-12): 8
College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired): BRICKlayer
16b. Kind of Business/Industry: MaSonary

17. Father's Name (First, Middle, Last): Levi Dennis
18. Mother's Name (First, Middle, Maiden Surname): Daisey School Field

19a. Informant's Name/Ralationship (Type, Print): Carrie Dennis
19b. Mailing Address (Street and Number or Rural Route Numbar, City or Town, State, Zip Code): 1758 SAND PIT Rd Pocomoke city md 21851

20a. Method of Disposition: 1 X Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FIRST BAPT CH. Date: 1/3/98
20c. Location - City or Town, State: Mappsville VA.

21. Signature of Funaral Service Licensee: ▶ Keith E. Wharton
22. Name and Address of Facility: WHARTON FUNERAL Home 22171 Wharton Rd ACCOMAC, VA. 23301

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximata Interval Between Onset and Death

Immediate Cause (Final disease or condition rasulting in death): a. BRONCHOGENIC CARCINOMA & METASTASIS — FEW MONTHS

Dua to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ASCVD

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 X No
24b. Ware autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was cese refarred to medical examinar? 1 X Yes 2 ☐ No

28. Placa of Daath (Check only ona)
Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA
Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify)

27. Manner of Death: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be datermined

28a. Data of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☐ **Certifying Phyaician**: To the best of my knowledga, daath occurrad at the time, date and place, and due to the cause(s) and mannar as statad. 2 X **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to tha causa(s) and manner stated.

29b. Signature and title of certifier: ▶ Dorothy C. Holzworth M.D.
29c. Licensa number: D06241
29d. Date signed (Month, Day, Year): 12-31-97

30. Name and address of person who completed causa of daath (Item 23a) (Type, Print): DOROTHY C. HOLZWORTH, M.D. 203 SNOW ST. SNOW HILL MD. 21863

State Registrar

31. Date filed (Month, Day, Yaar): DEC 31 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41281

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Vera L. Dunson
2. Date of Death Month / Day / Year: 12- 22- 97
3. Time of Death: 2:10 am
4a. Facility Name *(If not institution, give street end number)*: Garrett Memorial Hospital
4b. City, Town, or Location of Death: Oakland
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 226-44-7993
6. Sex: 1☐ M 2☐ F
7. Age *(In yrs. last birthday)* Yrs. / If Under 1 Year: Months / Days / If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12/19/36
9. Birthplace *(State or Foreign Country)*: WV

Usual Residence of Decedent

10a. State: WV
10b. County: Preston
10c. City, Town or Location: Terra Alta
10d. Inside City Limits: 1☒ Yes 2☐ No XX
10e. Street and Number: 211 Sanders st.
10f. Zip Code: 26764
10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced XX
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: XX
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No XX *Specify:* white
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker
16b. Kind of Business/Industry: domestic

17. Father's Name *(First, Middle, Last)*: William L. Metheny
18. Mother's Name *(First, Middle, Maiden Surname)*: Nona E. Bolyard

19a. Informant's Name/Relationship *(Type, Print)*: Edwin F. Dunson husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 211 Sanders st, Terra Alta, WV. 26764

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Oak Grove Cemetery
Date: 12/26/97
20c. Location - City or Town, State: Terra Alta, WV.

21. Signature of Funeral Service Licensee: Mark D Sell
22. Name and Address of Facility: Arthur H. Wright Funeral Home, Inc. 105 Highland ave., Terra Alta, WV, 26764

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Dilated cardiomyopathy	2 yr.
Due to (or as a consequence of): b.	Atherosclerotic coronary vasc dis.	10 yr.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Chronic obstructive pulmonary dis.	10 yr.
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Scleroderma

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. Licensa number: D42464
29d. Date signed *(Month, Day, Year)*: 12/22/97

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997
32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41282

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELIZABETH A. GILBERT
2. Date of Death Month: NOV Day: 06 Year: 1997
3. Time of Death: 0721
4a. Facility Name (If not institution, give street and number): HARFORD MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: HAVRE DE GRACE
4c. County of Death: HARFORD

Funeral Director

5. Social Security Number: 220-40-8194
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 55 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): NOV 25 1941
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: HARFORD
10c. City, Town or Location: ABERDEEN
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 127 HANOVER ST APT E
10f. Zip Code: 21001
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): DISABILITY
16b. Kind of Business/Industry: Labor

17. Father's Name (First, Middle, Last): THEODORE E. GILBERT
18. Mother's Name (First, Middle, Maiden Surname): REBECCA A. COOPER

19a. Informant's Name/Relationship (Type, Print): SHIRLEY ANN TURNER/DAU
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 127 HANOVER ST APT E ABERDEEN, MD. 2100

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): GREENMOUNT CEMETERY Date: 11/8/97
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: ▶
22. Name and Address of Facility: DEARO FUNERAL HOME 552 LEWIS ST. HAVRE DE GRACE, MD 21078

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. ACUTE M.I.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CAD

DM

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: D42800
29d. Date signed (Month, Day, Year): 11/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 319 S. UNION AVE, HDG, MD, 21078

State Registrar

31. Date filed (Month, Day, Year): DEC 22 1997
32. Registrar's Signature: ▶ [illegible] Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41283

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARCUS LEROY GANTT
2. Data of Death (Month, Day, Year): DECEMBER 31, 1997
3. Time of Death: 09:00a.m.
4a. Facility Name (If not institution, give street and number): Calvert Memorial Hospital
4b. City, Town, or Location of Death: Prince Frederick
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 216-24-5595
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): Nov. 11, 1928
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Lusby
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12535 Olivet Road
10f. Zip Code: 20657
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armad Forcas? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grada completed): Elementery/Secondary (0-12): 2 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Laborer
16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Marcus Timothy Gantt
18. Mother's Name (First, Middle, Maiden Surname): Sarah Janey

19a. Informant's Name/Relationship (Type, Print): Audrey Gantt/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 115 Lusby, MD 20657

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of camatary, crematory or other place): Eastern UM Chr. Cem. | Date: 1/3/98
20c. Location - City or Town, State: Lusby, MD

21. Signature of Funeral Service Licensaa: ▶ Blache G. Sewell
22. Nama and Address of Facility: Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD 20678

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter tha moda of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on eech line. | Approximete Interval Between Onset and Deeth

Immediate Cause (Final diseese or conditlon resulting in death): a. UROSEPSIS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last:
b. HYPOXIC ENCEPHALOPATHY
Due to (or as a consequence of):
c.
Due to (or as a consequance of):
d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying causa given in Part I.: Hypertension Atrial flutter Sarcoidosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☐ No
26. Plece of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residenca 8☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated.
29b. Signature and title of certifier: ▶ David J Tardio MD
29c. License number: 047610
29d. Date signed (Month, Day, Year): 12/31/97
30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): Dr. David J. Tardio, M.D., Prince Frederick, Maryland 20678

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998
32. Registrer's Signature: ▶ Lisa Davidson Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 end 2 should be filled within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

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State of Maryland / Department of Health and Mental Hygiene

Amended #1, & #5, PG, GC, 1/2/98

Certificate of Death

Reg. No. 97 41284

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Griffin, Narcissus Griffin
2. Date of Death: Month 12 Day 28 Year 97
3. Time of Death: 5:00pm
4a. Facility Name (If not institution, give street and number): Sinia Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 246-70-1122
6. Sex: 1☐ M 2☑ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3 21-1932
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5026 Pembridge ave
10f. Zip Code: 21215
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Indusiry: Private

17. Father's Name (First, Middle, Last): Sherman Peele
18. Mother's Neme (First, Middle, Maiden Sumame): Alade Unknown

19a. Informant's Name/Relationship (Type, Print): Annie Hudgins
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 2311 Lawnwood circle Baltimore Md 21207

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other placa): Ironside
Date: 1-2-98
20c. Location - City or Town, State: Ironside, Md

21. Signature of Funeral Service Licensee: ▶ Jack Dillard Jr 847
22. Name end Address of Facility: L.W.PLUNKETT INC FUNERAL HOME 2504 28th st.northeast Washington,D.C. 20018

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do noi enier the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lisi only one cause on each line.

		Approximete Interval Between Onset and Death
Immedieie Cause (Finel disease or condition resulting in death)	e. Cardiac Arrythmia	1 hr
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last	b. Metabolic Abnormality	1 m
Due to (or as a consequence of):		
	c. Diabetes Mellitus	10 yrs
Due to (or as a consequence of):		
	d.	

Part II. **Other signficant conditiona** contributing to death but not resulting in the underlying cause given in Part I.: Lymphocytosis

23b. Did tobacco uae contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and pleca, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Tyler Cooper, DO
29c. License number: H43157
29d. Date signed (Month, Day, Year): 12/28/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 2435 W. Belvedere Baltimor MD 21215

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998
32. Registrar's Signature: Julia Strauss-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41285

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Raymond Lawrence Ludden
2. Date of Death Month Day Year: December 31, 1997
3. Time of Death: 3:15 p.m.
4e. Facility Name *(If not institution, give street end number)*: 140 Patuxent Mobile Home
4b. City, Town, or Location of Death: Lothian
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 477 05 6036
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthdey)*: 81 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Year)*: Dec. 12, 1916
9. Birthplece *(Stete or Foreign Country)*: MN

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Anne Arundel
10c. City, Town or Location: Lothian
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 140 Patuxent Mobile Home
10f. Zip Code: 20711
10g. Citizen of What Country?: USA

11. Maritel Stetus: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes: 1942-45
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 10 / College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: school bus driver
16b. Kind of Business/Industry: transportation

17. Father's Neme *(First, Middle, Last)*: Lawrence Ludden
18. Mother's Neme *(First, Middle, Maiden Surneme)*: Anna Mary Tschida

19e. Informent's Neme/Relationship *(Type, Print)*: Mayo E. Ludden/wife
19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: same as 10 above

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Metropolitan Crematory
Dete: 1-2-98
20c. Location - City or Town, Stete: Alexandria, VA

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Neme end Address of Fecility: Rausch Funeral Home, Owings, MD 20736

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. METASTATIC COLON CANCER — 2 YEARS

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leeding to Immediete cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

28. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Nelurel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 8☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medicel Exeminer:** On the basis of exemination end/or investigetion, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ Peter Wisniewski
29c. License number: D40370
29d. Date signed *(Month, Dey, Year)*: 1/1/98

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Peter L. Wisniewski, M.D. Prince Frederick, MD 20678

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 05 1998
32. Registrer's Signeture: ▶ [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8+1 gratis

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41286

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PETER LUCH

2. Date of Death (Month, Day, Year): December 28, 1997

3. Time of Death: 430 AM

4a. Facility Name (If not institution, give street and number): 2844 Byrd Road

4b. City, Town, or Location of Death: Pocomoke City

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 291-16-5973

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 75 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7/11/22

9. Birthplace (State or Foreign Country): West Virginia

Usual Residance of Decedant

10a. State: Maryland

10b. County: Worcester

10c. City, Town or Location: Pocomoke City

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 2844 Byrd Road

10f. Zip Code: 21851

10g. Citizen of Whet Country?: USA

11. Marital Status: 1 [ ] Naver Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1 [X] Yes 2 [ ] No If Yas, Giva Year or Datas: Navy 1943-47

13. Was Decedant of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1 [ ] Yas 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedant's Educetion (Specify only highast grada complatad)

Elamantary/Secondary (0-12): 11

Collega (1-4or 5+): -

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Farmer

16b. Kind of Business/Industry: Poultry Farming

17. Fathar's Nama (First, Middla, Last): John Luch

18. Mothar's Nama (First, Middla, Maidan Surname): Sophia Lucina

19a. Informant's Name/Ralationship (Type, Print): Betty Luch/Wife

19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 2844 Byrd Rd., Pocomoke City, MD 21851

20a. Mathod of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Ramoval from Stata 4 [ ] Donetion 5 [ ] Othar (Specify)

20b. Piace of Disposition (Name of cametary, cramatory or othar place): Goodwill Methodist Cemetery

Date: 12/30/97

20c. Location - City or Town, Stata: Pocomoke City, MD

21. Signatura of Funaral Sarvica Licensaa: Michael A Dean

22. Nama and Addrass of Facility: Holloway-Melson Funeral Home, 103 Linden Ave., Pocomoke City, MD 21851

Physician /Medical Examiner

23a. Part1. Entar tha disasa, or complicetions thet caused tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in death)

a. Acute Myocardial Infarction — hours

Dua to (or as a consequance of):

Sequantially list conditions, if any, laading to immediata ceusa. Entar Underlying Cause (Disaasa or Injury that initiatad evants rasulting in daath) Last

b.

Dua to (or as a consequance of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying ceuse given in Part I.

Chronic Obstructive Lung Disease

23b. Did tobacco use contributa to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to complation of ceusa of death? 1 [ ] Yes 2 [ ] No

Medical Certification: To Be Completed by Physician/Medical Examiner

25. Was cesa rafarred to medical examinar? 1 [ ] Yas 2 [X] No

28. Piace of Death (Check only one): Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA; Othar: 4 [ ] Nursing Homa 5 [X] Residance 8 [ ] Othar (Specify)

27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding investigation 6 [ ] Could not be datarminad

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Dascribe how injury occurred

28a. Piace of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifiar (Check only one): 1 [X] **Certifying Physician:** To the best of my knowladga, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar as statad. 2 [ ] **Medical Examinar:** On the basis of axamination and/or invastigation, in my opinion, daath occurrad at the tima, data and place, and dua to the cause(s) and mannar stated.

29b. Signatura and title of certifiar: Ronald P. Tarwite MD

29c. Licansa number: D36576

29d. Data signed (Month, Day, Year): 12/30/97

30. Nama and addrass of person who complated ceusa of daath (Item 23a) (Type, Print): RONALD P. TARWITE MD 560 RIVERSIDE DR SALISBURY MD 21801

3 of 1

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41287

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edna Curtis McAtee
2. Date of Death (Month, Day, Year): December 27, 1997
3. Time of Death: 7:00 PM
4a. Facility Name (If not institution, give street and number): Dennett Road Manor Nursing Home
4b. City, Town, or Location of Death: Oakland
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 234-38-9003
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 92 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 23, 1905
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10e. State: WV
10b. County: Grant
10c. City, Town or Location: Bayard
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: P.O. Box 35
10f. Zip Code: 26707
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8th | College (1-4or 5+):
18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Grocery Store
17. Father's Name (First, Middle, Last): David William McAtee
18. Mother's Name (First, Middle, Maiden Surname): Ella Emerella Michael
19a. Informant's Name/Relationship (Type, Print): Janet Wilson/Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box, Bayard, West Virginia 26707
20e. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bayard Cemetery
Date: 12/29/97
20c. Location - City or Town, State: Bayard, WV
21. Signature of Funeral Service Licensee: Bradley J. Stewart
22. Name and Address of Facility: Stewart Funeral Home 32 S. Second St., Oakland, MD 21550

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Congestive Heart Failure — 12 months
Due to (or as a consequence of):
b. Atherosclerotic Heart Disease — 5 years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Breast Carcinoma
Noninsulin Dependent Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: MD
29c. License number: D27205
29d. Date signed (Month, Day, Year): 12/28/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Karl E. Schwalm, 311 N. 4th St., Oakland, MD 21550

State Registrar

31. Date filed (Month, Day, Year): JAN 2 1998
32. Registrar's Signature: Gabi Shreckengast

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41288

10 Amended#5/19 P.G.C. 1-12-98 cr

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedant's Neme (First, Middle, Last): Robert Pinckney

2. Dete of Death — Month: December; Dey: 27; Year: 1997

3. Time of Death: 1245pm

4a. Facility Name (If not institution, giva street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Deeth: Baltimore

Funeral Director

5. Social Security Number: 578-03-4067 ~~578-64-3481~~

6. Sex: 1☒ M 2☐ F

7. Aga (In yrs. last birthday): 86 Yrs.

If Under 1 Yaar — Months: ; Days:

If Under 24 Hrs. — Hours: ; Min.:

8. Date of Birth (Month, Day, Year): Apr 4, 1911

9. Birthplaca (State or Foraign Country): South Carolina

Usual Rasidance of Decadent

10a. Stete: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Temple Hills

10d. Insida City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5618 Lambert Drive

10f. Zip Code: 20748

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Merriad 3☒ Widowad 4☐ Divorcad

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No. If Yas, Give Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- if Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No Specify:

14. Race - Amarican Indian, Black, Whita, atc. Specify: Black

15. Dacedant's Education (Specify only highast grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired): Clerk

16b. Kind of Business/Industry: Government

17. Fathar's Nama (First, Middle, Last): Jacob Pinckney, Sr.

18. Mothar's Nama (First, Middle, Maidan Surneme): Julia Drayton

19a. Informant's Name/Relationship (Type, Print): God Rel King ~~Grand~~ Daughter

19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code): 5618 Lambert Drive, Temple Hills, Md. 20748

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or othar placa): Cedar Hill Cemetery

Deta: Jan 3,1998

20c. Location - City or Town, Stata: Suitland, Md.

21. Signatura of Funaral Sarvice Licansee: ▶ Alex S Pope Jr M589

22. Nama and Address of Facility: ALEXANDER S. POPE FUNERAL HOMES 2617 Pennsylvania Avenue, SE DC 20020

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on each line.

Approximata Intarval Between Onsat and Death

Immediete Ceusa (Finai disaasa or condition resulting in daath): a. End Stage Renal Disease

Dua to (or as a consequence of): b. Hypertension

Sequentially list conditions, if eny, laading to immadiate ceuse. Entar Underlying Causa (Disaasa or injury that initiated evants rasulting in death) Last

Dua to (or as a consequanca of): c.

Dua to (or as a consequanca of): d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to completion of cause of daath? 1☐ Yas 2☐ No

25. Was casa refarrad to medical examiner? 1☐ Yas 2☑ No

28. Placa of Death (Check only one)

Hospital: 1☑ Inpatiant 2☐ ER/Outpatiant 3☐ DOA

Othar: 4☐ Nursing Home 5☐ Rasidanca 6☐ Othar (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding investigation 6☐ Could not be datarmined

28a. Date of Injury (Month, Day Yaar)

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Cartifiar (Check only one): 1☑ **Certifying Physician:** To tha best of my knowledga, daath occurred at tha time, date and placa, and dua to the causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar statad.

29b. Signatura end titia of certifiar: ▶ Savitha Nukal M.D

29c. Licansa number: 09502A

29d. Data signed (Month, Dey, Yaar): 12/27/97

30. Nama and addrass of person who complatad causa of daath (Item 23a) (Type, Print): Savitha Nukal, M.D. C/o Maryland General

State Registrar

31. Date filed (Month, Day, Yaar): DEC 31 1997

32. Registrar's Signatura: Julia Thurlow Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Robert Pinkney
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41289

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Maurice Wilson Pilchard

2. Date of Death Month: 12 Day: 29 Year: 1997

3. Time of Death: 20:47

4a. Facility Name *(If not institution, give street and number)*: Misty Harbor Boat Landing

4b. City, Town, or Location of Death: Snow Hill

4c. County of Death: Worcester

Funeral Director

5. Social Security Number: 218-34-9323

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 89 Yrs. If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 7/15/1908

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Snow Hill

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 4523 Outten Road

10f. Zip Code: 21863

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yaar or Dates:

13. Was Dacedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 [ ] Yea [X] No *Specify:*

14. Raca - American Indian, Black, White, atc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 5; College (1-4or 5+):

18a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Waterman/Farmer

16b. Kind of Business/Industry: self-employed

17. Father's Nama *(First, Middla, Last)*: Alonza Pilchard

18. Mother's Name *(First, Middla, Maiden Surname)*: Molly Taylor

19a. Informant's Name/Relationship *(Type, Print)*: Eugene Pilchard / son

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 3410 Redden Rd., Pocomoke, Md. 21851

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Goodwill Methodist Cem.

Date: 1/2/98

20c. Location - City or Town, Stata: Pocomoke, Md.

21. Signature of Funeral Service Licensee: Michael A Dean

22. Name and Address of Facility: Holloway-Melson Funeral Home, 103 Linden Ave., Pocomoke, Md. 21851

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or reapiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ASPHYXIATION BY DROWNING — FEW MINUTES

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Last

b.

Due to (or as a consequance of):

c.

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Wara autopsy findings availeble prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was casa referred to medical exeminer? 1 [X] Yes 2 [ ] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)* CHINCOTEAGUE BAY

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicida 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be datermined

28a. Date of Injury *(Month, Day Year)*: 12-29-97

28b. Time of Injury: 20:00 M

28c. Injury at Work? 1 [ ] Yes [X] No

28d. Describe how injury occurred: DECEASED THREW HIMSELF INTO BAY (TIED TO WALKER)

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*: BAY (CHINCOTEAGUE)

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: PUBLIC LANDING, MD.

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To tha bast of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On tha basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner atated.

29b. Signature and title of certifier: Dorothy C. Holworth, M.D.

29c. Licensa number: D06244

29d. Date signed *(Month, Day, Year)*: 12-31-97

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): DOROTHY C. HOLZWORTH, M.D. 203 SNOW ST. SNOW HILL, MD. 21863

10

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 31 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41290

SEARLES, Joseph ANTHony

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Anthony Searles

2. Date of Death (Month, Day, Year): December 26 1997

3. Time of Death: 0740 AM

4a. Facility Name (If not institution, give street and number): Doctors Community Hospital

4b. City, Town, or Location of Death: LANHAM

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-22-8872

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 30, 1910

9. Birthplace (State or Foreign Country): Connecticut

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: College Park

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 8408 49th Avenue

10f. Zip Code: 20740

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Director

16b. Kind of Business/Industry: Patton Research Invention, Inc

17. Father's Name (First, Middle, Last): James Joseph Searles

18. Mother's Name (First, Middle, Maiden Surname): Elizabeth Dowd

19a. Informant's Name/Relationship (Type, Print): Rosalie J. Searles - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8408 49th Avenue, College Park, Maryland 20740

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery

Date: 12/29/97

20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: ▶ Henry R. Ford

22. Name and Address of Facility: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

CR

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Septicemia — 5 days.
Due to (or as a consequence of): old age.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Poor Nutritional Status
Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year): N/A

28b. Time of Injury: N/A M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No N/A

28d. Describe how injury occurred: N/A

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State): N/A

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Mahen Sonde

29c. License number: D50514

29d. Date signed (Month, Day, Year): 12/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mehru Mahen Sonde - 6510 Kenilworth Ave. Riverdale Maryland.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(6)

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997

32. Registrar's Signature: ▶ Julie Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41291

Physician /Medical Examiner

1. Decadent's Name *(First, Middle, Last)*: LILLIAN STEWART SZABO

2. Dete of Deeth: Month DECEMBER Day 30 Yeer 1997

3. Time of Death: 4:10 AM

4a. Facility Name *(If not institution, give street and number)*: Berlin Nursing & Rehabilitation Center

4b. City, Town, or Location of Deeth: Berlin

4c. County of Deeth: Worcester

Funeral Director

5. Social Securify Numbar: 183-01-5686

6. Sax: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 7/26/12

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residance of Dacedent

10e. State: Maryland

10b. County: Worcester

10c. City, Town or Location: Pocomoke City

10d. Inside City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 215 10th St., Apt. 118

10f. Zip Coda: 21851

10g. Citizan of Whet Country?: USA

11. Meritel Stafus: 1☐ Navar Marriad 2☐ Marriad 3☒ Widowed 4☐ Divorcad

12. Wes Decedant Evar in U.S. Armad Forcas? 1☐ Yes 2☒ No If Yas, Giva Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, etc. *Specify:* White

15. Decedent's Educetion *(Specify only highest greda compliatad)*: Elementery/Secondary (0-12): 10 — College (1-4or 5+): -

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Secretary

16b. Kind of Businass/Industry: Banking

17. Fether's Nama *(First, Middla, Last)*: Herbert Stewart

18. Mothar's Name *(First, Middla, Maiden Sumame)*: Bertha Johanna Elizabeth Kalbacher

19a. Informant's Name/Relationship *(Type, Print)*: Susan E. Collins/Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 653 Rt. 518, Skillman, NJ 08558-2510

20a. Mathod of Disposition: 1☐ Buriel 2☒ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cemetery, cremetory or othar place)*: Salisbury Crematory

Data: 12/31/97

20c. Location - City or Town, Stata: Salisbury, MD

21. Signeture of Funaral Sarvica Licensaa: Michael A Dean

22. Nama and Addrass of Facility: Holloway-Melson Funeral Home 103 Linden Ave., Pocomoke City, MD 21851

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that ceusad the daath. Do not anter the moda of dying, such as cardiac or respiratory errest, shock, or haart failura. List only ona causa on aach lina.

		Approximate Intervel Between Onsat and Death
Immediete Ceusa (Final disaasa or condition resulting in daath) a.	Cardiac Tamponade	7 weeks
Due to (or as a consequence of): b.	Pericardial Effusion	7 weeks
Sequentielly list conditions, if any, leading to immediata cause. Entar Underlying Causa (Disease or injury that initiated avants resulting in deeth) Last — Dua to (or as a consequence of): c.	Metastatic Adenocarcinoma of Pericardium	8 weeks
Due to (or as a consequence of): d.	from Undetermined Primary	

Part II. **Othar significant conditions** contributing to death but not resulting in tha underlying ceuse given in Part I.

Chronic Obstructive Pulmonary Disease

Essential Hypertension

Gastroesophageal Reflux Disease

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Wara autopsy findings available prior to complation of ceuse of daath? 1☐ Yas 2☒ No

25. Wes cesa referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Othar: 4☒ Nursing Home 5☐ Residenca 8☐ Othar *(Specify)*

27. Mannar of Daath: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the best of my knowladge, daath occurred at tha tima, data and placa, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or invastigetion, in my opinion, death occurred at tha tima, data and placa, and dua to tha ceusa(s) and mennar stated.

29b. Signature and title of certifier: Gregorio Belloso MD

29c. Licansa number: D29505

29d. Data signed *(Month, Day, Year)*: 12-30-97

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): GREGORIO BELLOSO,M.D. 5302 CHINABERRY DR. SALISBURY, MD 21801

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 31 1997

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 97 41292

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mabel Catherine Stanton
2. Date of Death (Month Day Year): December 23, 1997
3. Time of Death: 10:10 PM
4a. Facility Name (If not Institution, give street and number): Goodwill Mennonite Home
4b. City, Town, or Location of Death: Grantsville
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 219-20-6695
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan 13, 1925
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Garrett
10c. City, Town or Location: Accident
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 33482 Garrett Highway
10f. Zip Code: 21520
10g. Citizen of What Country: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name (First, Middle, Last): Louis Hoover
18. Mother's Name (First, Middle, Maiden Surname): Stella Stein
19a. Informant's Name/Relationship (Type, Print): Virginia C. Fike/daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 112 Main St., Ext., Accident, MD 21520
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Bittinger Cemetery, Dec 27, 1997
20c. Location - City or Town, State: Bittinger, MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Newman Funeral Homes, P.A., P.O. Box 275 179 Miller St., Grantsville, MD 21536

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Dehydration	2 days
Due to (or as a consequence of):		
b.	Chronic Renal Failure	2 years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c.	Diabetes Mellitus	25 years
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D25759
29d. Date signed (Month, Day, Year): 12-24-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Walter K. Naumann, M.D. 106 Cemetery Road Accident, MD 21520

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-7524-023
AM
SANDRA
SHAFFER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41293

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sandra Kay Shaffer
2. Date of Death (Month, Day, Year): DECEEMBER 28, 1997
3. Time of Death: 0615 A
4a. Facility Name (If not institution, give street and number): 453 BETHLEHEM RD.
4b. City, Town, or Location of Death: Oakland
4c. County of Death: GARRETT

Funeral Director

5. Social Security Number: 220-58-0239
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 45 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 30, 1952
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Garrett
10c. City, Town or Location: Oakland
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 216 Gank Road
10f. Zip Code: 21550
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Home

17. Father's Name (First, Middle, Last): Roy Frank Elliott
18. Mother's Name (First, Middle, Maiden Surname): Lucretta Lorraine Wood

19a. Informant's Name/Relationship (Type, Print): Phillip A. Pepe, Jr./Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 62, Oakland, Maryland 21550

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Garrett Co. Mem. Gardens
Date: 1/2/98
20c. Location - City or Town, State: Oakland, MD

21. Signature of Funeral Service Licensee: ▶ Bradley A. Stewart
22. Name and Address of Facility: Stewart Funeral Home, 32 S. Second St., Oakland, MD 21550

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death: Sudden

Immediate Cause (Final disease or condition resulting in death): a. Multiple Injuries
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) MVA

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): 12/28/97
28b. Time of Injury: 540 A M
28c. Injury at Work? 1☐ Yes 2☑ No
28d. Describe how injury occurred: motor vehicle collision
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): street
28f. Location (Street and Number or Rural Route Number, City or Town, State): 453 Bethlehem Road Garrett Co. Md

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Dennis J. Chute MD
29c. License number: OCME
29d. Date signed (Month, Day, Year): DECEMBER 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 2 1998
32. Registrar's Signature: Julie Druckenbrod

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To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41294

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): RITA M. TARQUINI (RITA MARY TARQUINI)
2. Dete of Death — Month: 12 Dey: 27 Yeer: 97
3. Time of Deeth: 18:55
4e. Feciliity Neme (If not institution, giva street and number): Harford Memorial Hospital
4b. City, Town, or Location of Deeth: Havre de Grace
4c. County of Deeth: Harford

Funeral Director

5. Social Security Number: 213-26-5271
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 69 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Day, Year): 10/03/1928
9. Birthplace (Stete or Foreign Country): MD

Usuel Residence of Decedent

10e. Stete: MD
10b. County: Harford
10c. City, Town or Location: Havre de Grace
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 608 Lafayette St.
10f. Zip Code: 21078
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexicen, Puerto Ricen, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - Americen Indian, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 11th; College (1-4or 5+):
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Owned Restaurant
16b. Kind of Business/Industry: Restaurant
17. Fethar's Nema (First, Middle, Last): Eugene Vigna
18. Mother's Neme (First, Middle, Meiden Surnema): Luigina Mazzuca
19a. Informant's Name/Relationship (Type, Print): Armando Tarquini- Husband
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code): 608 Lafayette St. Havre de Grace, MD 21078
20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Mt. Erin Cemetery
Date: 12/30/97
20c. Location - City or Town, State: Havre de Grace, MD
21. Signature of Funerel Service Licensee: George M. Hampton Jr
22. Neme end Address of Feciliity: Mitchell-Smith Funeral Home, P.A. 123 S. Washington St. Havre de Grace, MD

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions that ceused the death. Do not antar the mode of dying, such es cardiec or respiratory arrest, shock, or heert feilure. List only one ceuse on eech line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): e. SEPTICEMIA — 12-15-97

Due to (or es e consequence of):

Sequentielly list conditions, if any, leeding to immediete ceuse. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Last:

b. METHICILLIN RESISTANT STAPH INFECTION 7-97

Due to (or es e consequence of):

c. Chronic Renal Failure — 2 years

Due to (or es e consequence of):

d. Arteriosclerotic Heart Disease — 2 years

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Respiratory Failure
Chronic Anemia
Diffuse Cerebral Encephalopathy

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings aveileble prior to completion of ceusa of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner**: On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: attending M.D.
29c. License number: D-15994
29d. Date signed (Month, Day, Year): 12-29-97

30. Name end eddress of persen who completed cause of deeth (Item 23e) (Type, Print): LETICIA S. GALVEZ, M.D. 625 S. UNION AVE. Havre de Grace Md. 21078

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 31 1997
32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

R.I.P. Mary Tarquini December 27, 1997 1651 Live

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41295

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hulda Ellen WHITE
2. Date of Death (Month Day Year): 12/21/97
3. Time of Death: 4:40AM
4a. Facility Name (If not institution, give street and number): Dennett Road Manor Nursing Home
4b. City, Town, or Location of Death: Oakland
4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 218-52-7007
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 8/18/97
9. Birthplace (State or Foreign Country): West Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Garrett
10c. City, Town or Location: Mt. Lake PArk
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 607 P St. Apt #1
10f. Zip Code: 21550
10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeper
16b. Kind of Business/Industry: HOmes

17. Father's Name (First, Middle, Last): John Murray White
18. Mother's Name (First, Middle, Maiden Surname): Hester Jane Lower

19a. Informant's Name/Relationship (Type, Print): Jean Tressler/Friend
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 201 Sciote Ave, Oakland, MD 21550

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Pleasant Valley Cemetery
Date: 12/23/97
20c. Location - City or Town, State: Oakland, MD

21. Signature of Funeral Service Licensee: Bradley A. Stewart
22. Name and Address of Facility: Stewart Funeral Home, 32 S. Second St., Oakland MD 21550

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. congestive heart failure	years
Due to (or as e consequence of):	atherosclerotic heart disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initieted events resulting in death) Last	b. Due to (or as a consequence ot):	
	c. Due to (or es a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

diabetes mellitus

aortic stenosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: HP
29c. License number: D5333
29d. Date signed (Month, Day, Year): 12/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas G. Johnson, M.D. 311 N. Fourth St Oakland, MD 21550

State Registrar

31. Date filed (Month, Day, Year): JAN 2 1998
32. Registrar's Signature: Julie Strickler Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 7,8 Per FH, 24a Per Phy Film G-755 1-20-98RC

Certificate of Death

97 41296

Reg. No.

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: GERALD IVAN MILLS

2. Date of Death — Month: DECEMBER Day: 29 Yaar: 1997

3. Tima of Deeth: 5:23pm

4a. Facility Name *(If not institution, give street and number)*: The Johns Hopkins Hospital

4b. City, Town, or Location of Daath: Baltimore

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 217-38-3985

6. Sex: 1☑ M 2☐ F

7. Age *(In yrs. last birthday)*: 54 ~~57~~ Yrs. — If Under 1 Yaar: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Yaar)*: ~~12/29/1997~~ 04/13/1943

9. Birthplace *(State or Foraign Country)*: WestVirginia

Usuel Residence of Decedant

10a. State: MD

10b. County: N/A

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☑ Yas 2☐ No

10e. Street and Number: 2045 E. Fairmont Ave.

10f. Zip Coda: 21231

10g. Citizan of What Country?: USA

11. Maritei Status: 1☐ Navar Married 2☐ Married 3☐ Widowed 4☑ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1☐ Yes 2☑ No — If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yaa or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☑ No *Specify:*

14. Raca - Amarican Indian, Black, Whita, etc. *Specify:* White

15. Decedant's Education *(Spacify only highest grada complatad)*: Elamentary/Secondary (0-12): 6 — Collaga (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: Welder

16b. Kind of Businass/Industry: Factory

17. Fathar's Name *(First, Middla, Last)*: Gerald D. Mills

18. Mothar's Nama *(First, Middle, Maidan Surnama)*: Laura L. Klepfer

19a. Informant's Name/Relationship *(Type, Print)*: Judith Ambrose Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 312 West Ave. Redlion PA 17356

20a. Mathod of Disposition: 1☐ Burial 2☑ Cremation 3☐ Ramoval from State 4☐ Donation 5☐ Othar *(Spacify)*

20b. Placa of Disposition *(Nema of cemetery, cramatory or othar placa)*: Greenmount Cemetery — Data: 1/3/98

20c. Location - City or Town, Stete: Baltimore Md

21. Signatura of Funaral Sarvica Licansaa: ▶ Kathleen Weber CFSP

22. Nama and Address of Facility: David J. Weber Funeral Home 401 S. Chester St. Baltimore, Md. 21231

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications thet caused tha daath. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart teilura. List only one ceusa on each line.

Approximate Interval Between Onsat and Deeth

Immediata Causa (Final disaase or condition resulting in daath)

a. ADULT RESPIRATORY DISTRESS SYNDROME — 2 weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, laading to immadiete cause. Enter Underlying Cause (Disease or injury thet initietad avants resulting in death) Last

b.

Due to (or es e consaquanca of):

c.

Dua to (or as a consaquence of):

d.

Part II. **Othar significant conditions** contributing to daath but not resulting in tha underlying causa givan in Part I.: LARYNGEAL CANCER

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performad? ~~1☐ Yes~~ 2☒ No

24b. Wera autopsy findings available prior to compiation of cause of daath? 1☐ Yas 2☒ No

25. Was case rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be determinad

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straet, factory, offica building, atc. *(Spacify)*

28f. Location *(Streat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, deeth occurred at tha tima, data and place, and dua to tha cause(s) and mannar as steted. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, death occurred at tha tima, data and placa, and dua to tha cause(s) and manner statad.

29b. Signature and title of certifier: ▶ Matthew T. Yeatman, M.D. HOUSE OFFICER

29c. Licansa number: RES-000

29d. Data signed *(Month, Day, Year)*: DECEMBER 29, 1997

30. Name and eddrass of person who compiatad causa of daath (Item 23a) (Type, Print): MATTHEW T. YEATMAN, M.D. JOHNS HOPKINS HOSPITAL

State Registrar

31. Data filad *(Month, Day, Year)*: JAN 20 1998

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item #24a,25,27 per PHY G755 1/21/98 EW

Certificate of Death

Reg. No. 97 41297

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BLAND MASSIE

2. Date of Death Month Day Year: 11 - 7 - 97

3. Time of Death: 14:38

4a. Facility Name *(If not institution, give street and number)*: PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE-GEORGES

Funeral Director

5. Social Security Number: 225-52-1900

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 56 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 06-04-41

9. Birthplace *(State or Foreign Country)*: VA

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Landover

10d. Inside City Limits: 1☐Yes 2☐No

10e. Street and Number: 1440 Capitol View k Ter.

10f. Zip Code: 20758

10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Chef

16b. Kind of Business/Industry: Restaurant

17. Father's Name *(First, Middle, Last)*: Clarence Massie

18. Mother's Name *(First, Middle, Maiden Surname)*: Virginia Fisher

19a. Informant's Name/Relationship *(Type, Print)*: Shirley Smith

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2671 Berry Hill Road Nellyford, VA 22958

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Oakwood Cemetery

Date: 11-16-97

20c. Location - City or Town, State: Charlottesville, VA

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: R.L. Gilliam Funeral Home Inc. 203 8th St. NW Charlottesville, VA 22903

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart failure

Due to (or as a consequence of):

b. Renal Insufficiency

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Hypertension

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☒ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D46591

29d. Date signed *(Month, Day, Year)*: 11/10/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): NDU ACHUFUSI 7940 JOHNSON AVE. GLENARDEN MD 20706

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 21 1998

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41298

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Francis V. Schillaci
2. Date of Death (Month, Day, Year): December 31, 1997
3. Time of Death: 1:10 PM
4a. Facility Name *(If not institution, give street and number)*: 3701 Altondale Road
4b. City, Town, or Location of Death: Reistertown
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 215-22-8873
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sept. 27, 1913
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Reisterstown
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 3701 Altondale Road
10f. Zip Code: 21136
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Fire Fighter
16b. Kind of Business/Industry: unknown

17. Father's Name *(First, Middle, Last)*: Charles Schillaci
18. Mother's Name *(First, Middle, Maiden Surname)*: Rose Restivo

19a. Informant's Name/Relationship *(Type, Print)*: Evelyn A. Schillaci/wife
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3701 Altondale Road, Reisterstown, Maryland 21136

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State 4☒Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetary, crematory or other place)*
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimre, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Renal Failure — 1 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Coronary artery disease — 3 years
Due to (or as a consequence of):
c. Diabetes mellitus
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA | Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D38915
29d. Date signed *(Month, Day, Year)*: 1/7/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FREISI 295 Acre Westminster 21157

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 20 1998
32. Registrar's Signature

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item:25 per MD G-755 1/20/98 dh

Certificate of Death

Reg. No. 97 41299

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael Vischansky, Jr.

2. Date of Death (Month, Day, Year): November 10, 1997

3. Time of Death: 2:26 AM

4a. Facility Name (If not institution, give street and number): Baltimore Vet. Admin. Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 179-14-4389

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): November 11, 1919

9. Birthplace (State or Foreign Country): PA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: --

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 508 Mirabile Lane

10f. Zip Code: 21224

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Machinist

16b. Kind of Business/Industry: Aircraft Mfg.

17. Father's Name (First, Middle, Last): Michael VisChansky

18. Mother's Name (First, Middle, Maiden Surname): Mary Costy

19a. Informant's Name/Relationship (Type, Print): Catherine VisChansky Ackley/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 445 Fairway Ave., Elmira, NY 14904

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): S S Peter & Paul Cemetery

Date: Nov. 15, 1997

20c. Location - City or Town, State: N. Towanda Twp., PA

21. Signature of Funeral Service Licensee: J.J. Hartenstein

22. Name and Address of Facility: J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: K9264 All 4176435

29d. Date signed (Month, Day, Year): November 10, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Unmi Kim, MD BUAMC, 10. N. Greene Street, Baltimore, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 2 0 1998

32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f allow any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41300

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margarita Ascencio Anaya

2. Date of Death (Month, Day, Year): December 31, 1997

3. Time of Death: 4:29 PM

4a. Facility Name (If not institution, give street and number): 12806 Parkland Drive

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-94-1079

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 3, 1907

9. Birthplace (State or Foreign Country): El Salvador

Usual Residence of Decedent

10e. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 12806 Parkland Drive

10f. Zip Code: 20853

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☒ Yes 2☐ No Specify: El Salvadoran

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Aureliano Ascencio

18. Mother's Name (First, Middle, Maiden Surname): Maria Salome

19a. Informant's Name/Relationship (Type, Print): Efrain Anaya/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12806 Parkland Drive, Rockville, Maryland 20853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery

Date: 1/5/1998

20c. Location - City or Town, State: Silver Spring, MD.

21. Signature of Funeral Service Licensee: Michael D Gillon

22. Name and Address of Facility: DeVol Funeral Home, 10 East Deer Park Dr., Gaithersburg, MD. 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. MALIGNANT NON-HODGKINS LYMPHOMA — 1 yr

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D29675

29d. Date signed (Month, Day, Year): JAN 2, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): RONALD BOCCARDO MD 9707 MEDICAL CTR DR #300 ROCKVILLE

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

:ended Item #31, per Carroll County, 01/05/98, wjl

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item 20b, per F.D. 01/05/98, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41301

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Hamida Begum

2. Date of Death — Month: Dec. Day: 30, Year: 1997

3. Time of Death: 5:00am

4a. Facility Name *(If not institution, give street and number)*: 6423 Michael Elizabeth Way

4b. City, Town, or Location of Death: Hanover

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 213-29-4152

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Yaar — Months: Deys:

If Under 24 Hrs. — Hours: Min.:

8. Date of Birth *(Month, Dey, Year)*: Nov 26, 1926

9. Birthplece *(Steta or Foreign Country)*: Pakistan

Usuel Residence of Decedent

10a. Stete: MD

10b. County: Anne Arundel

10c. City, Town or Location: Hanover

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 6423 Michael Elizabeth Way

10f. Zip Code: 21076

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yeer or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Americen Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12 College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Domestic

17. Father's Nama *(First, Middle, Last)*: Mirza Abdul Majid

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Amtul Quresh

19a. Informent's Neme/Relationship *(Type, Print)*: Mr. Yousaf Jan (son)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Steta, Zip Code)*: 6423 Michael Elizabeth Way Hanover, MD 21076

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Lake View Mem. Park Date: 1/1/98 ~~1/1/97~~

20c. Location - City or Town, Stete: Sykesville, MD

21. Signeture of Funerel Service Licensee: Brian D. Haight

22. Nama and Address of Facility: HAIGHT FUNERAL HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part1. Enter tha diseese, or complications that caused tha daath. Do not anter the mode of dying, such es cardiac or respiretory arrest, shock, or heert failure. List only one cause on eech line.

Approximete Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)

e. CARDIO RESPIRATORY ARREST

Due to (or es e consequence of):

Sequentielly list conditions, if any, leeding to Immediete cause. Enter Underlying Cause (Disease or Injury thet Initieted events resulting in deeth) Last

b. DEHYDRATION

Due to (or es e consequence of):

c. RENAL FAILURE

Due to (or es e consequence of):

d. METASTATIC CARCINOMA OF PANCREAS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- MALNUTRITION
- ELECTROLYTE IMBALANCE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yas 2☒ No

24b. Were autopsy findings evelleble prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 8☐ Other *(Specify)*

27. Menner of Death: 1☒ Naturet 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Ptece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.
To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, end due to the ceuse(s) end manner as steted. 2☐ **Medical Examiner:** On the besis of examinetion end/or Investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner stated.

29b. Signeture and title of certifier: manyualan

29c. License number: D 29748

29d. Data signed *(Month, Day, Year)*: 12/30/97

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): ALI F MANEJWALA. MD 1307 CRAIN HWY. S.E. GLEN BURNIE MD 21061

State Registrar

31. Dete filed *(Month, Day, Year)*: ~~12/30/97~~

32. Registrer's Signeture: JAN 05 1998 Julia Strickler Randall

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41302

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT BELLI

2. Date of Death Month Day Year: DEC 28 97

3. Time of Death: 1257P

4a. Facility Name (If not Institution, give street and number): Montgomery General

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 159-28-8127

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 7, 1935

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2309 Holly Spring Drive

10f. Zip Code: 20905

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1955-1980

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Colonel

16b. Kind of Business/Industry: U.S. Army

17. Father's Name (First, Middle, Last): William Belli

18. Mother's Name (First, Middle, Maiden Surname): Faye (Surname unobtainable)

19a. Informant's Name/Relationship (Type, Print): Mala Belli / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2309 Holly Spring Drive, Silver Spring, Maryland 20905

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cem.

Date: 1/13/98

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Hines-Rinaldi Funeral Home

22. Name and Address of Facility: Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. MYOCARDIAL INFARCTION — ACUTE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

28. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Francis C Mayle

29c. License number: D07094

29d. Date signed (Month, Day, Year): DEC 29 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): FRANCIS C MAYLE 10215 FERNWOOD RD BETHESDA MD 20817

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JAN 09 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41303

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): IRMA T BECK
2. Dete of Death Month: DEC Dey: 31 Yeer: 97
3. Time of Death: 2220P
4a. Facility Neme (If not institution, give street end number): Suburban Hospital
4b. City, Town, or Location of Deeth: Bethesda
4c. County of Death: Montgomery

Funeral Director

5. Sociel Security Number: 578-22-6424
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Yeer: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): Aug. 22, 1922
9. Birthplece (Stete or Foreign Country): Washington, D.C.

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Bethesda
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 4603 West Virginia Avenue
10f. Zip Code: 20814
10g. Citizen of Whet Country?: U.S.A.
11. Meritel Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, Whita, etc. Specify: White
15. Dacedent's Education (Specify only highest grede completed): Elementary/Secondery (0-12): 12 / College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home
17. Fether's Neme (First, Middle, Last): Joseph Tucci
18. Mother's Name (First, Middle, Maiden Surneme): Adelina Ritta
19a. Informant's Neme/Reletionship (Type, Print): Jesse E. Beck (husband)
19b. Meiling Address (Streat end Number or Rural Route Number, City or Town, Stete, Zip Code): 4603 West Virginia Avenue Bethesda, Maryland 20814
20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Gate of Heaven Cemetery
Dete: 1/5/98
20c. Location - City or Town, Stete: Silver Spring, Maryland
21. Signature of Funeral Service Licensee: Robert E Ramsey
22. Neme end Address of Feciliity: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Pert 1. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feilura. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel disease or condition resulting in daath): a. MYOCARDIAL INFARCTION — 2 DAYS

Dua to (or as e consequenca of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disaase or injury thet initiated events resulting in deeth) Lest:

b. Due to (or es e consequenca of):

c. Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Pert I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes casa referred to medical examiner? 1☒ Yes 2☐ No

26. Piece of Deeth (Check only ona): Hospitel: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be datarmined

28a. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Dascribe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office buiiding, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifiar (Check only one): 1☐ **Certifying Physician:** To the best of my knowledga, daath occurred at tha time, date and pleca, and due to the ceuse(s) end manner as stated. 2☒ **Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, daeth occurred et the time, date end place, and due to the cause(s) end manner stated.

29b. Signeture and title of exeminer:

29c. License number: D07099

29d. Date signed (Month, Dey, Yeer): JAN 2 98

30. Nama and address of parson who completed causa of death (Item 23a) (Typa, Print): FRANCIS C MAYLE 10215 FERNWOOD RD BETHESDA MD 20817

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 05 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

IRMA T. BECK Dec 31 '97 10:20 pm

Burial

RKD
97-7548-031
juilius
BECKER III

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41304

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Julius Theodore Becker, III
2. Date of Death Month Day Year: DECEMBER 30, 1997
3. Time of Death: 2:50P.M.
4a. Facility Name *(If not institution, give street and number)*: 8811 COLESVILLE ROAD
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 215-54-5509
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 48 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 9, 1949
9. Birthplace *(State or Foreign Country)*: Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8811 Colesville Road
10f. Zip Code: 20910
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Rece - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Warehouseman
16b. Kind of Business/Industry: Federal Express

17. Father's Name *(First, Middle, Last)*: Julius T. Becker, Jr.
18. Mother's Name *(First, Middle, Meiden Surneme)*: Stella M. Greene

19a. Informant's Name/Reletionship *(Type, Print)*: Stella M. Becker (mother)
19b. Mailing Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 3400 Chatham Road, Adelphi, MD 20783

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Metropolitan Crematory
Date: 1/3/97
20c. Location - City or Town, State: Alexandria, VA

21. Signeture of Funeral Service Licensee: [signature]
22. Name end Address of Fecility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on eech line. — Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Smothering
Due to (or es e consequence of):
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? Partial 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Wes cese referred to medicel exeminer? 1☒ Yes 2☐ No
26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Dete of Injury *(Month, Day Year)*: 12-30-97
28b. Time of Injury: 12 30 PM
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: subject placed plastic bag over head
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: Residence
28f. Location *(Street and Number or Rurel Route Number, City or Town, Stete)*: 8811 Colesville Rd

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medtcal Examiner:** On the basis of examinetion end/or investigation, In my opinion, death occurred at the time, date and ptace, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: O.C.M.E.
29d. Dete signed *(Month, Dey, Year)*: DECEMBER 31, 1997
30. Name end address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 06 1998
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mentel Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41305

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): RICHARD BIENVENUE

2. Dete of Deeth — Month: December; Dey: 31; Year: 1997

3. Time ot Death: 4:00A.M.

4a. Facility Nema (If not Institution, give street and number): 615 Dunberry Drive

4b. City, Town, or Location of Death: Arnold

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 088-09-0683

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Day, Year): Oct. 26, 1910

9. Birthplace (State or Foreign Country): Manchester, N.H.

Usual Residence of Decedent

10a. Stete: Md.

10b. County: Anne Arundel

10c. City, Town or Location: Arnold

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street end Number: 615 Dunberry Drive

10f. Zip Code: 21012

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1 ☐ Never Merried 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Giva Yeer or Dates: 1943-1945

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indien, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 — College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Federal Investigator

16b. Kind ot Business/Industry: Civil Service Commission

17. Father's Name (First, Middle, Last): Henry J. Bienvenue

18. Mother's Name (First, Middle, Maiden Surname): Rose Mary Potier

19a. Interment's Name/Reletionship (Type, Print): Richard Bienvenue / son

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4716 Davenport St., N.W. Wash. D.C. 20016

20a. Method ot Disposition: 1 ☐ Buriel 2 ☒ Cremation 3 ☐ Removal trom Stete 4 ☐ Donetion 5 ☐ Other (Specify)

20b. Placa of Disposition (Neme of cemetery, crematory or other placa): Metropolitan Crematory

Date: 1/4/1998

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Servica Licensee: [signature]

22. Neme end Address of Facility: DeVol Funeral Home, 2222 Wisc. Ave., N.W. Wash. D.C. 20007

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel diseese or condition resulting in death)

a. CORONARY ARTERY DISEASE — 8 YEARS

Due to (or es e consequence ot):

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 10 YEARS

Sequantially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that Initieted events resulting in deeth) Last

Due to (or as a consequanca ot):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

OSTEOARTHRITIS

PERIPHERAL NEUROPATHY

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy tindings aveileble prior to completion ot cause ot death? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical examinar? 1 ☐ Yes 2 ☒ No

26. Place of Deeth (Check only one): Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Menner ot Death: 1 ☒ Neturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time ot Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place ot Injury - At home, farm, street, tectory, office building, etc. (Specify)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best ot my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) and menner as steted. 2 ☐ **Medical Examiner**: On the basis ot examinetion and/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) and manner stated.

29b. Signeture end title ot certifier: [signature]

29c. License number: D04899

29d. Date signed (Month, Day, Year): 12/31/97

30. Neme end eddress ot person who completed cause ot deeth (Item 23e) (Type, Print): DENNIS HAND M.D. 4203 QUEENSBURY ROAD HYATTSVILLE, MD 20781

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the buriel-transit

Division of Vital Records, P.O. Box 68760,

20

State Registrar

31. Dete filed (Month, Day, Year): JAN 06 1998

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Items:6,18 per FH G-757 3/5/98 dh

Reg. No. 97 41306

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Loran Clay Byler

2. Date of Death Month Day Year: Dec 30, 1997

3. Time of Death: 8:20 PM

4a. Facility Name (If not institution, give street and number): 10801 Seven Oaks Drive

4b. City, Town, or Location of Death: Fort Washington

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-40-6264

6. Sex: 1 ☐ XX M 2 ☐ F

7. Age (In yrs. last birthday): ~~75~~ 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jan 2, 1923

9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decadant

10a. State: MD

10b. County: P.G.

10c. City, Town or Location: Fort Washington

10d. Inside City Limits: 1 ☐ Yes 2 XX No

10e. Street and Number: 10801 Seven Oaks Drive

10f. Zip Code: 20744

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married XX Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? XX ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 ☐ Yes XX No Specify:

14. Race - American Indian, Black, White, atc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 8th | College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Supervisor of Returned Merchandise

16b. Kind of Business/Industry: Ginns Warehouse

17. Father's Name (First, Middle, Last): Harris G. Byler

18. Mother's Nama (First, Middle, Maiden Surname): Allie Bland Clay

19a. Informant's Name/Relationship (Type, Print): Allie Mae Neilsen

19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code): 17701 Magruder's Ferry Road, Brandywine, Md 20613

20a. Method of Disposition: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or othar place): Fort Lincoln Cemetery

Date: Jan 7, 1998

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Address of Facility: Lee Funeral Home,Inc 6633 Old Alexandria Ferry Road,Clinton,Md 20735

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart feilure. List only one cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Finel disease or condition resulting in death) a. lung CA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco uae contribute to the cause of death?** 1 ☐ **Yes** 2 ☐ **No** 3 ☐ **Probably** 4 ☑ **Unknown**

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Piece of Death (Check only one): Hospital: 1 ☐ Inpatient NA 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)

27. Menner of Death: 1 ☑ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day Year): NA

28b. Time of Injury: NA M

28c. Injury at Work? NA 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred: NA

28e. Place of injury - At home, farm, straet, factory, office building, etc. (Specify): NA

28f. Location (Street and Number or Rurel Route Number, City or Town, Steta): NA

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of exemination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. Licansa number: D45881

29d. Data signed (Month, Day, Year): 12/31/97

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): Philip Wisotsky, M.D. 700 Old Line Center #207, Waldorf, Md 20602

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 1998

32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41307

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: DONALD C. CUTSAIL

2. Data of Death Month / Dey / Yeer: 12/29/97

3. Time of Death: 7:38 p.m.

4a. Facility Neme *(If not institution, giva street end number)*: 4833 Buffalo Road

4b. City, Town, or Location of Daath: Mt. Airy

4c. County of Death: Carroll

Funeral Director

5. Sociel Security Number: 212-28-5737

6. Sax: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Deta of Birth *(Month, Dey, Year)*: July 28 1929

9. Birthplaca *(Stata or Foreign Country)*: Maryland

Usuel Residence ot Decedent

10e. Stete: Md

10b. County: Carroll

10c. City, Town or Location: Mt. Airy

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 4833 Buffalo Road

10f. Zip Code: 21771

10g. Citizen of Whet Country?: USA

11. Merital Status: 1☐Navar Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- It Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Reca - Amarican Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12): 10 / College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Giva kind of work done during most of working life. DO NOT use retired)*: truck driver

16b. Kind ot Business/Industry: transportation

17. Father's Name *(First, Middla, Last)*: Raymond F. Cutsail

18. Mother's Neme *(First, Middle, Meiden Surnema)*: Mildred Zentz

19e. Interment's Name/Reletionship *(Type, Print)*: Mrs. Jean Cutsail (spouse)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 4833 Buffalo Road, Mt. Airy, Md. 21771

20e. Method ot Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donetion 5☐Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, crematory or other place)*: Lake View Memorial Park

Date: 1-1-98

20c. Location - City or Town, State: Sykesville, Md.

21. Signature of Funeral Service Licensee: ▶ Brian L. Haight

22. Name and Address ot Facility: Haight Funeral Home & Chapel, P.O. Box 195 Sykesville, Md. 21784

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only ona cause on each line.

Approximete Interval Between Onsat and Death

Immediete Causa (Final diseese or condition resulting in death)

e. IDIOPATHIC PULMONARY FIBROSIS — 8 months

Due to (or es e consequence ot):

Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequence ot):

c.

Due to (or es e consequence ot):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying ceuse given in Part I.

NON INSULIN DEPENDENT DIABETES MELLITUS

23b. Did tobacco uaa contribute to the causa of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings availeble prior to completion of ceuse of deeth? 1☐Yas 2☒No

25. Wes cesa referred to medical examiner? 1☐Yes 2☒No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 8☐Other *(Specify)*

27. Menner of Deeth: 1☒Neturet 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place ot Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Numbar or Rural Route Number, City or Town, Stete)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒**Certifying Physician**: To the best ot my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted. 2☐**Medical Examiner**: On the basis ot exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated.

29b. Signetura end title ot certifier: ▶ Thomas K. Galvin Jr m

29c. License number: D31660

29d. Date signed *(Month, Dey, Year)*: 12/30/97

30. Neme and address of person who completed cause ot deeth (Item 23e) (Type, Print): THOMAS K. GALVIN MD 295 STONER AVENUE WESTMINSTER MD 21157

State Registrar

31. Data filed *(Month, Dey, Yeer)*: JAN 05 1998

32. Registrer's Signeture: Julia Davidson Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours aftar daath.
To the Funeral Director: After this certificate has been signed by the attending physician and completaly filled in by tha funeral director, paga 2 should be detached for usa as tha burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with tha Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41308

DELORIS CORBIN
247-76-5950
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DELORIS CORBIN
2. Date of Death (Month, Day, Year): DECEMBER 29, 1997
3. Time of Death: 0435
4a. Facility Name (If not institution, give street end number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 247-76-5950
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 53 Yrs. (If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.)
8. Date of Birth (Month, Day, Year): 05-14-1944
9. Birthplace (State or Foreign Country): Allendale, S.C.

Usual Residence of Decedent

10a. State: MD
10b. County: Wicomico
10c. City, Town or Location: Salisbury
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1015 N. Division ST.
10f. Zip Code: 21801
10g. Citizen of What Country?: U.S

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): House wife
16b. Kind of Business/Industry: Private Home

17. Father's Name (First, Middle, Last): George Chisolm
18. Mother's Name (First, Middle, Maiden Surname): Virginia Breland

19a. Informant's Name/Relationship (Type, Print): Chauncey Corbin / Husband
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 1015 N. Division ST. Salisbury, MD 21801

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Macedonia Church Cem. Date: 1-7-98
20c. Location - City or Town, State: Westover, MD

21. Signature of Funeral Service Licensee: John D. Prince
22. Name and Address of Facility: Anthony E. Ward Funeral Home 30639 Hampden Ave - Princess Anne, MD 21853

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
b. ?
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
DIABETES.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Yeer)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner es steted. 2☐ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated.

29b. Signature end title of certifier: C Stegman MD
29c. License number: D25219
29d. Date signed (Month, Dey, Year): 12-29-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHARLES STEGMAN MD 30434 MT VERNON RD PRINCESS ANN. MD

State Registrar

31. Date filed (Month, Day, Year): JAN - 7 1998
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41309

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Nannie Davis

2. Date of Death Month: 12 Day: 30 Year: 97

3. Time of Death: 4:15 AM

4a. Facility Name *(If not institution, give street and number)*: 37 E. George St.

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 215-44-0331

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 73 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 7, 1924

9. Birthplace *(State or Foreign Country)*: West Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Carroll

10c. City, Town or Location: Westminster

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 37 E. George St.

10f. Zip Code: 21157

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: Brit Abshire

18. Mother's Name *(First, Middle, Maiden Surname)*: Ester Robinson

19a. Informant's Name/Relationship *(Type, Print)*: Gloria J. Wright/ daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 13 Barnhart Rd. Westminster, MD 21158

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Neme of cametery, crematory or other place)*: Haugh's Cemetery

Date: 1/3/98

20c. Location - City or Town, State: Ladiesburg, MD

21. Signature of Funeral Service Licansee: ▶ Catharine O. Hartler

22. Name end Address of Facility: Hartzler Funeral Home 310 Church St. New Windsor, MD 21776

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only one causa on aach line.

Approximate Interval Between Onsat and Death

Immediate Causa (Final disaase or condition resulting in daath)

a. Carcinoma lung → bone — Jan '98.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to Immediate causa. Entar Underlying Cause (Diseasa or Injury that Initiated events resulting in death) Last

b.

Due to (or es e consequenca of):

c.

Due to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

Paraplegia 2° To 23a

Carotid Stenosis

Hypothyroidism

23b. Did tobacco use contribute to the causa of death? ☒1 Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of daath? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes ☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residenca 6☐ Other *(Specify)*

27. Manner of Death: ☒1 Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Dascribe how Injury occurred

28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: ☒1 **Certifying Physician:** To tha best of *my* knowledge, death occurred at the tima, data and place, and dua to tha causa(s) and *manner* as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD

29c. License number: D 906

29d. Dete signed *(Month, Dey, Year)*: 12/30/97

30. Name and address of person who completed cause of daath (Item 23a) (Type, Print): J. H. CARICOFE MD. Ex 1110 Union Bridge, Md 21791

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requiras thet the death certificate be axecuted within 24 hours after death.

To the Funeral Director: Aftar this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41310

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Laverne Norma Dingledy

2. Date of Death (Month, Day, Year): December 19,1997

3. Time of Death: 9:28 P.M.

4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 279-14-2099

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 18,1915

9. Birthplace *(State or Foreign Country)*: Wisconsin

Usual Residence of Decedent

10a. State: Md.

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 5400 Vantage Point Road

10f. Zip Code: 21044

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker

16b. Kind of Business/Industry: own home

17. Father's Name *(First, Middle, Last)*: Thomas Smith

18. Mother's Name *(First, Middle, Maiden Surname)*: Wilhemina Kieter

19a. Interment's Name/Relationship *(Type, Print)*: Barbara Ryan/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1183 Putnam Blvd., Wallingford, Pa. 19086

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: Dec.22,97

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: James H. Wolf

22. Name and Address of Facility: DeVol Funeral Home 2222 Wisconsin Ave.,N.W.,Washington,DC 20007

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Multiple Organic System Failure — Weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: David Kessler

29c. License number: D11929

29d. Date signed *(Month, Day, Year)*: January 6,1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): David Kessler, M.D., 7610 Carroll Ave.,#480, Takoma Park, Md. 20912

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41311

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Sarah Hill Doyle
2. Deta of Deeth — Month: Dec Dey: 31 Yeer: 97
3. Time of Death: 17:52
4a. Facility Neme (If not institution, give street end number): 98 Mary Lou Drive
4b. City, Town, or Location of Death: Lothian
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 236 16 6332
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Deta of Birth (Month, Day, Year): April 16,1910
9. Birthpleca (State or Foraign Country): West Virginia

Usuel Residenca of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Lothian
10d. Insida City Limits: 1☐ Yes 2☒ No
10e. Street end Number: 98 Mary Lou Drive
10f. Zip Code:
10g. Citizen of Whet Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Datas:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grada completed): Elementery/Secondery (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk
16b. Kind of Business/Industry: Federal Government

17. Fathar's Name (First, Middle, Last): Jesse Homer Hill
18. Mother's Neme (First, Middle, Meiden Surnama): Cora Southworth

19a. Intormant's Name/Relationship (Type, Print): Gary E. Doyle
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 5728 Pindell Road , Lothian , Maryland 20711

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stata 4☐ Donetion 5☐ Other (Specify)
20b. Place ot Disposition (Neme of cemetery, cremetory or other piece): Fort Lincoln Cemetery — Date: Jan 5, 1998
20c. Location - City or Town, Stata: Brentwood,Maryland

21. Signature of Funeral Service Licensee: [signature] A. Hoff
22. Name and Address of Facility: Lee Funeral Home,Inc 6633 Old Alexandria Ferry Road, Clinton,Md 20735

Physician /Medical Examiner

23a. Part I. Enter tha disaase, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on each line. — Approximate Interval Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in death): e. Arteriosclerotic Heart Disease UNK

Due to (or es e consequence ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseesa or Injury thet initieted events resulting in deeth) Lest

b. Due to (or es e consequence ot):

c. Dua to (or es e consequenca of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion ot cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☒ Yes 2☐ No

28. Plece of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Homa 5☒ Residance 6☐ Other (Specify)

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determinad

28a. Dete ot Injury (Month, Day Year)
28b. Time ot Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece ot Injury - At home, ferm, street, factory, office building, etc. (Spacify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☐ **Certifying Phyaician:** To tha best ot my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis ot exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date and placa, and due to the cause(s) end menner stated.

29b. Signetura and title of certifier: [signature] MD
29c. License number: D06054
29d. Dete signed (Month, Day, Yeer): 1/2/98

30. Neme end eddress ot person who completed cause ot deeth (Item 23e) (Type, Print): William P. Jones, M.D. 695 American Ct. 21035

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 1998
32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41312

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Addie Bell Winder Ford

2. Data of Death Month: December Day: 29 Year: 1997

3. Time of Death: 9:10 am

4a. Facility Neme *(If not institution, give street and number)*: Wicomico Nursing Home

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 219-05-3565

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 100 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Deta of Birth *(Month, Dey, Year)*: Oct.30 1897

9. Birthplece *(State or Foreign Country)*: Maryland

Usual Residence ot Decedent

10a. Stete: Maryland

10b. County: Wicomico

10c. City, Town or Location: Hebron

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 416 Chestnut Street

10f. Zip Code: 21830

10g. Citizan of What Country?: U.S.A

11. Maritei Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Evar in U,S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispanic Origin? (Specify Yas or No- It Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Bleck, White, etc. *Specify:* Black

15. Decedant's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 4 | College (1-4or 5+):

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic

16b. Kind of Businass/Industry: None

17. Fathar's Nema *(First, Middle, Last)*: John Winder

18. Mother's Neme *(First, Middle, Meiden Surname)*: Meleshia Allen

19e. Informent's Neme/Reletionship *(Type, Print)*: Grand Peggy Ann Layton (Daughter

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1343 West 7th St.Chester,PA 19013

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Remouel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Nema of cemetery, cremetory or othar piece)*: Cem. Rockawalkin Church

Data: 1/3-98

20c. Location - City or Town, Stata: Hebron,Md.

21. Signeture of Funerel Service Licansee: Gladys B. Stewart

22. Neme end Addrass of Fecility: Stewart Funeral Home 821 West Rd.Salisbury,Md.21801

Physician /Medical Examiner

23a. Part1. Entar the diseasa, or complicetions thet caused tha death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heert failure. List only one cause on aach line.

Approximate Interval Between Onset and Death

Immediete Ceusa (Final diseese or condition resulting in deeth)

a. Cerebrovascula Accident, left, thrombosis — 24 days

Due to (or as a consequence of):

b. Generalized Atherosclerosis — 5 yrs

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

Hyperthyroidism
Essential Hypertension
Pneumonia

23b. Did tobacco use contributs to the cause of death? 1☐ Yee 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, streat, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Cartifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred at the time, dete end piece, end due to the cause(s) end menner steted.

29b. Signature and title of certifier: Gregorio M. Belloso M.D.

29c. License number: D29505

29d. Date signed *(Month, Day, Year)*: Dec. 29, 1997

30. Neme and address of person who completed cause ot death (Item 23a) (Type, Print): GREGORIO M. BELLOSO, M.D. 5302 CHINABERRY DRIVE, SALISBURY, MD 21801

State Registrar

31. Deta filed *(Month, Day, Year)*: DEC 31 1997

32. Registrer's Signature: Julia Anderson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

FORD, ADDIE

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #7, 1/6/98, BMW, Mont.g Co.

Certificate of Death

97 41313
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sophia Fox
2. Date of Death: Month Dec Day 31 Year 1997
3. Time of Death: 0135am
4e. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-03-7368
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): ~~81~~ 79 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): May 13, 1918
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decadent

10e. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9039 Sligo Creek Pkwy. #201
10f. Zip Code: 20901
10g. Citizen of Whet Country?: United States

11. Meritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bieck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 12 | College (1-4or 5+):
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): House Wife
16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Last): Michael Taylor
18. Mother's Name (First, Middle, Maiden Surname): Ida (unknown)

19a. Informent's Neme/Reletionship (Type, Print): Harvey Jacobs-Legal Rep.
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 11300 Rockville Pike Rockville, MD 20852

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Beth Shalom Cong. Cemetery
Dete: 1/1/98
20c. Location - Clty or Town, Stete: Capital Heights, MD

21. Signeture of Funerel Servi[illegible] Licensee: ▶ Edward Sagel -Edward Sagel
22. Name end Address of Facility: Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, MD 20852

BMW

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heert failure. List only one ceuse on eech line. (Approximate Interval Between Onset end Deeth)

Immediate Ceuse (Finel diseese or condition resulting in deeth): a. organic brain syndrome
Due to (or es a consequenca of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet Initiated events resulting in deeth) Lest:
b. Due to (or es e consequenca of):
c. Due to (or es e consequenca of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24e. Wes en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical exeminer? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospitel: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: ▶ Gerald A. Heckman, M.D.
29c. License number: D05373
29d. Date signed (Month, Dey, Year): 12/31/97

30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print): 8830 Cameron St. Silver Spring, Maryland

State Registrar

31. Dete filed (Month, Dey, Year): JAN 06 1998
32. Registrer's Signeture: Julia Davidson-Rogers

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended Item #7, per F.D. 01/05/98, Carroll County, wjl

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41314

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BENJAMIN GRANT

2. Date of Death (Month, Day, Year): DECEMBER 30,97

3. Time of Death: 4:50PM

4a. Facility Name (If not institution, give street and number): NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 218-30-6535

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): ~~61~~ 62 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 16 1935

9. Birthplace (State or Foreign Country): WV

Usual Residence of Decedent

10a. State: Md.

10b. County: Carroll

10c. City, Town or Location: Sykesville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 1017 Grandview Avenue

10f. Zip Code: 21784

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decadent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - Americen Indian, Black, White, etc. Specify: white

15. Decadent's Education (Specify only highest grede completed)

Elementary/Secondery (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): auto trimmer/ upholstry

16b. Kind of Business/Industry: automotive

17. Father's Name (First, Middle, Last): Thomas Donald Grant

18. Mother's Name (First, Middle, Malden Surneme): Myrtle K. Chumbley

19a. Informant's Name/Relationship (Type, Print): Mrs. Mary Jane Grant (wife)

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 1017 Grandview Ave. Sykesville, Md. 21784

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Neme of cemetery, crematory or other piece): Lake View Memorial

Date: 1-2-98

20c. Location - City or Town, State: Sykesville, Md.

21. Signature of Funeral Service Licensee: Brian L. Haight

22. Name and Address of Facility: Haight Funeral Home & Chapel P.O. Box 195 Sykesville, Md. 21784

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock, or heert feilure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death)

a. CEREBRO VASCULAR ACCIDENT — DAYS

Due to (or as a consequenca of):

b. PNEUMONIA — 3 WEEKS

Sequentiaily list conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CROHNS DISEASE

23b. Did tobacco use contribute to the cauee of death? 1 [ ] Yee 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings aveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth (Check only one)

Hospital: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, and due to the cause(s) end menner es stated. 2 [ ] **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29b. Signeture end title of certifier: K.S.RAO.M.D.

29c. License number: D43462

29d. Dete signed (Month, Dey, Year): DECEMBER 30, 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): K.S.RAO. M.D. NORTHWEST HOSPITAL CENTER, RANDALLSTOWN MD 21133

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Dey, Year): JAN 05 1998

32. Registrar's Signeture: Julie Strickler Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41315

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: WILLIAM RUSSELL GORMAN
2. Dete of Deeth Month Dey Yeer: DECEMBER 31, 1997
3. Time of Deeth: 9:30 AM
4e. Feciility Neme *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Deeth: ROCKVILLE
4c. County of Deeth: MONTGOMERY

Funeral Director

5. Sociel Security Number: 577-58-9299
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 87 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: Sept 10, 1910
9. Birthpleca *(State or Foreign Country)*: Tennessee

Usuel Residence of Decedent

10a. Stete: Maryland
10b. County: Montgomery
10c. City, Town or Location: Chevy Chase
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 4515 Willard Avenue, #806 South
10f. Zip Code: 20815
10g. Citizen of Whet Country?: United States

11. Maritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No — If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 5+
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Attorney
16b. Kind of Business/Industry: Law

17. Fether's Neme *(First, Middle, Last)*: William Gorman
18. Mother's Neme *(First, Middle, Maiden Surname)*: Kathryn Russell

19e. Informent's Name/Relationship *(Type, Print)*: Kathryn Gorman, Wife
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4515 Willard Avenue, #806S Chevy Chase, MD 20815

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Pleca of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory
Dete: Dec 31, 1997
20c. Location - City or Town, Stete: Alexandria, Virginia

21. Signeture of Fuperal Service Licensee: [signature]
22. Neme end Address of Feciility: DeVol Funeral Home 10 East Deer Park Drive, Gaithersburg, MD 20877

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

		Approximate Interval Between Oneet end Deeth
Immediate Ceuse (Final disease or condition resulting in death) e.	Pneumonia	days
Due to (or es a consequence of):		
Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in deeth) Last b.	Respiratory Failure	days
Due to (or es e consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Congestive Heart Failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings evellable prior to completion of ceuse of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No

28. Place of Deeth *(Check only one)*: Hospital: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, ferm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner**: On the beeis of examination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: [signature] M.D.
29c. License number: D20516
29d. Dete signed *(Month, Day, Yeer)*: Dec 31, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Joel Schulman 9410 Old Georgetown Rd Bethesda MD 20814

State Registrar

31. Dete filed *(Month, Day, Yeer)*: JAN 06 1998
32. Registrar's Signeture: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41316

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Francis Gibson,Jr.
2. Date of Death Month Day Yaar: December 29,1997
3. Time of Death: 10:50 Am
4a. Facility Name *(If not institution, giva street and number)*: Malcolm Grow Medicl Center
4b. City, Town, or Location of Daath: Camp Springs
4c. County of Death: P.G.

Funeral Director

5. Social Security Number: 012 12 8993
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 79 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Oct 12, 1918
9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: MD
10b. County: P.G.
10c. City, Town or Location: Forestville
10d. Inside City Limits: 1 [ ] Yea 2 [ ] No XX
10e. Street and Number: 1316 Inland Drive
10f. Zip Code: 20747
10g. Citizan of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [XX] Married 3 [ ] Widowed 4 [ ] Divorcad
12. Was Decedant Ever in U.S. Armed Forces? 1 [XX] Yes 2 [ ] No If Yes, Give Year or Dates: 1949 1963
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Rican, etc.): 1 [ ] Yes 2 [XX] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12; College (1-4or 5+): 7
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: Judge Adovocate/General Office
16b. Kind of Business/Industry: U.S. Airforce

17. Fathar's Name *(First, Middle, Last)*: Charles F. Gibson,Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Alice Howard

19a. Informant's Name/Relationship *(Type, Print)*: Robert J. Gibson
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1316 Inland Drive, Forestville, Md 20747

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cramatory or other place)*: Arlington National Cemetery
Date: Jan 7, 1998
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funaral Service Licensee: ▶ Katrina D. McCarthy
22. Nama and Address of Facility: Lee Funeral Home,Inc 6633 Old Alexnadria Ferry Rd, Clinton,Md 20735

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heert feilure. List only one ceuse on aach line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrhythmia — UNKNOWN

Due to (or es a consequence of):
b. Upper Gastrointestinal Bleeding — UNKNOWN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c. Atrial Fibrillation, Diabetes Mellitus, Cirrhosis — UNKNOWN

Due to (or es a consequence of):
d. Ascities, Enterococcus Infection — UNKNOWN

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [XX] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an autopsy performed? 1 [XX] Yes 2 [ ] No

24b. Were autopsy findinga available prior to completion of cause of death? 1 [ ] Yes 2 [XX] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [XX] No

26. Piece of Death *(Check only one)*: Hospital: 1 [XX] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Othar *(Specify)*

27. Manner of Death: 1 [XX] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, atreet, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [XX] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete and place, and due to the ceuse(s) end menner as stated. 2 [ ] **Medicat Examiner:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: NY 194060
29d. Date signed *(Month, Day, Year)*: December 29, 1997

30. Neme and address of person who completed ceuse of death (Item 23a) (Type, Print): Mary C. Brown, Capt, USAF, MC 89 MDG/1050 W Perimeter Rd Suite C1-7 Andrews Air Force Base, MD 20762

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 1998
32. Registrar's Signatura: John Anderson-Parker

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41317

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James J Godwin
2. Data of Deeth — Month: Dec · Dey: 29 · Year: 1997
3. Time of Deeth: 12:27 PM
4a. Facility Name (If not institution, give street end number): Southern Maryland Hospital
4b. City, Town, or Location of Deeth: Clinton
4c. County of Deeth: Prince George's

Funeral Director

5. Social Security Number: 233-64-1920
6. Sex: X 1☐ M 2☐ F
7. Age (In yrs. last birthday): 55 Yrs.
If Under 1 Year — Months / Deys:
If Under 24 Hrs. — Hours / Min.:
8. Date of Birth (Month, Dey, Year): July 16, 1942
9. Birthplece (State or Foreign Country): West Virginia

Usual Residance of Decedent

10e. Stete: W. VA
10b. County: Randolph
10c. City, Town or Location: Elkins
10d. Inside City Limits: 1☐ Yes 2☐ X No
10e. Street end Number: 8 River Street
10f. Zip Code: 26241
10g. Citizen of Whet Country?: U.S.A.

11. Meritai Stetus: 1☐ Never Married 2☐ Merried 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; Collega (1-4or 5+): 4
16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired): Journalist
16b. Kind of Business/Industry: Trentonian & Wall Street Journal

17. Fether's Neme (First, Middle, Last): Raynond Brown Godwin
18. Mother's Neme (First, Middle, Maiden Surname): Mary Frances O'Kernick

19a. Informent's Neme/Reletionship (Type, Print): Mary B. Hefner (Sister)
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 10202 White Avenue Clinton, Maryland 20735

20e. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other (Specify)
20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece): St. Brendan Cemetery
Dete: Jan. 3, 1998
20c. Location - City or Town, Stete: Elkins, W. VA

21. Signeture of Funerel Servica Licensee: ▶ Stu E. Lith
22. Neme end Address of Feciliity: Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, MD 20735

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the deeth. Do not enter the moda of dying, such es cardiec or raspiratory arrast, shock, or heert feilure. List only one ceuse on each fine.

Approximate Interval Between Onsef and Deeth

Immediete Ceuse (Final diseese or condition resulting in deeth): e. LUNG CARCINOMA / METASTATIC DISEASE — 3 months

Due to (or es e consequenca of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Disaasa or injury thet initieted events resulting in deeth) Lest

b. Dua to (or es e consaquance of):

c. Due fo (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Wara eutopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case refarred fo medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth (Check only ona): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA; Othar: 4☐ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Mannar of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarmined

28e. Dete of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha bast of my knowledge, deeth occurred et the time, dete end pleca, and due to the ceusa(s) end mennar es stated. 2☐ **Medical Examiner:** On the basis of axamination end/or investigetion, in my opinion, daath occurred et the time, date end place, and dua to tha causa(s) end menner steted.

29b. Signeture end title of certifier: ▶ R Gupta MD
29c. License number: D43346
29d. Date signed (Month, Dey, Yeer): 12/30/97

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): 8926 WOODYARD ROAD #201 CLINTON MD, 20735

State Registrar

31. Dete filed (Month, Day, Year): JAN 0 8 1998
32. Registrer's Signature: Phi Stevenson Parker

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41318

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Edith Elizabeth Householder

2. Date of Deeth: Month DEC. Dey 30 Yeer 1997

3. Time of Deeth: 2:10 A.M.

4e. Feclity Neme *(If not institution, give street end number)*: Mariner Health of Forest Hill

4b. City, Town, or Location of Deeth: Forest Hill

4c. County of Deeth: Harford

Funeral Director

5. Socisl Security Number: 218-10-6728

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 93 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: 5/27/1904

9. Birthplace *(Stete or Foreign Country)*: Maryland

Usuel Residence of Decedent

10e. Stete: MD.

10b. County: Harford

10c. City, Town or Location: Forest Hill (Cooptown)

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 1355 W. Jarrettsville Road

10f. Zip Code: 21050

10g. Citizen of Whet Country?: U.S.A.

11. Maritel Stetus: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* Caucasian

15. Decedent's Education *(Spscify only highest grede completed)*: Elementery/Secondary (0-12): 8; College (1-4or 5+): — —

16e. Decedent's Usuel Occupetion *(Giva kind of work done during most of working life. DO NOT usa retired)*: Clerk

16b. Kind of Business/Industry: Automobile Sales

17. Fether's Neme *(First, Middle, Last)*: Jacob Rusk

18. Mother's Nama *(First, Middle, Meiden Sumame)*: Anna Eichorn

19a. Informent's Neme/Reletionship *(Type, Print)*: F. Dorothy Schriver

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: same as #10

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: Carroll Cremation

Dete: 12/30

20c. Location - City or Town, Stete: Hampstead, Maryland

21. Signature of Funerel Service Licensee: M. Bladden Kurtz III

22. Neme end Address of Feclity: Kurtz Funeral Home, P.A. Jarrettsville, Maryland

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory errest, shock, or heert feilure. List only one ceuse on each line.

		Approximete Interval Between Onset end Deeth
Immediate Ceuse (Finel diseese or condition resulting in deeth) e.	Chronic Obstructive Pulmonary Disease	ten years
Due to (or es e consequence of):		
Sequentielly list conditions, if any, leeding to immedieta ceuse. Enter Underlying Causa (Disaase or injury thet initieted evants resulting in deeth) Lest b.		
Due to (or es e consequence of):		
c.		
Due to (or es e consequence of):		
d.		

Part II. **Other significent conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 1☐ Yes 2☒ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residance 8☐ Other *(Specify)*

27. Manner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, fectory, office building, etc. *(Spscify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, deta and place, and due to the cause(s) end menner es steted. 2☐ **Medical Examiner**: On the besis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: Mark P. Wild MD

29c. License number: d35522

29d. Dete signed *(Month, Dey, Yeer)*: December 30, 1997

30. Neme end eddress of person who completed causa of death (Item 23e) (Type, Print): Mark Wild 2 North Avenue Bel Air Maryland 21014

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 02 1998

32. Registrer's Signeture: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than 'natural', or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41319

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Herbert Hamilton

2. Date of Death Month / Day / Year: December 31, 1997

3. Time of Death: 8:15 AM

4a. Facility Name *(If not institution, give street and number)*: Washington Adventist Hospital

4b. City, Town, or Location of Death: Takoma Park

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 249-52-0703

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: October 1, 1933

9. Birthplace *(State or Foreign Country)*: South Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8210A Colonial Lane

10f. Zip Code: 20910

10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Unknown

16b. Kind of Business/Industry: Unknown

17. Father's Name *(First, Middle, Last)*: Willie Hoopendove

18. Mother's Name *(First, Middle, Maiden Surname)*: Estelle Hamilton

19a. Informant's Name/Relationship *(Type, Print)*: Deverly Preacher (Sister)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 707 24th Street, NE, Washington, DC 20002

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Chesapeake Crematory

Date: 1-2-98

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Eyle Lee L. Villella

22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Recurrent Sepsis — Weeks

Due to (or as a consequence of):

b. Respiratory Failure — Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Aspiration Pneumonia — Weeks

Due to (or as a consequence of):

d. Chronic Granulomatous and Obstructive Lung Disease

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Debilitated State; Diabetes Mellitus; Hepatic Encephalopathy; Extensive Decubiti Wound; Previous Alcoholism

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mohammed A. Mannan MD.

29c. License number: D24593

29d. Date signed *(Month, Day, Year)*: December 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mohammed A. Mannan, M.D., 3331 Toledo Terrace, Hyattsville, MD 20782

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41320

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Bertha Jones

2. Date of Death (Month, Day, Year): DECEMBER 20, 1997

3. Time of Death: 00:39

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 256-52-3940

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 59 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug 28, 1938

9. Birthplace (State or Foreign Country): GA

Usual Residence of Decedent

10a. State: MD

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 318 Popular Hill Ave.

10f. Zip Code: 21801

10g. Citizen of What Country?: U.S.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): n/a

16b. Kind of Business/Industry: n/a

17. Father's Name (First, Middle, Last): Rosevelt Dennis

18. Mother's Neme (First, Middle, Maiden Surname): Catherine Miller Dennis

19a. Informant's Name/Relationship (Type, Print): Gregory Coleman/son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 318 Popular Ave., Salisbury, MD 21801

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Cottage Grove Cemetery

Date: 12/26/97

20c. Location - City or Town, State: Westover, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility: Lewis N. Watson Funeral Home 1618 West Rd., Salisbury, MD 21801

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrest, shock, or heart feilure. List only one ceuse on each line.

		Approximete Interval Between Onset and Death
Immediete Cause (Finai disease or condition resulting in deeth) a.	Arrhythmia	40 Min
Due to (or as a consequence of): b.	End Stage Renal Disease	5 yrs
Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last Due to (or as a consequenca of): c.	Diabetes	14 yrs
Due to (or as a consequenca of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Kidney Transplant

23b. Did tobacco use contributa to the causa of death? 1☐ Yss 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner es steted. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and titia of certifier: MD

29c. License number: RES-000

29d. Data signed (Month, Day, Year): December 20, 1997

30. Neme end address of person who completed cause of death (Item 23e) (Type, Print): John Dunford 600 North Wolfe Street Baltimore MD 21287

State Registrar

31. Data filed (Month, Day, Year): DEC 30 1997

32. Registrar's Signature: Julia Davidson-Randall

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

2

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend #6 WCHD 1/5/98 **Certificate of Death** Reg. No: 97 41321

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Cameron Jolly

2. Date of Death Month Dey Year: Dec. 29 1997

3. Time of Death: 3:50 AM

4a. Facility Name (If not institution, give street and number): 1010 Fairground Drive

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 220-01-9806

6. Sex: 1 ☒ M 2 ☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Oct. 23 1912

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 1010 Fairground Drive

10f. Zip Code: 21801

10g. Citizen of What Country?: U.S.A

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Business/Industry: None

17. Father's Name (First, Middle, Last): Herbert Elzie

18. Mother's Name (First, Middle, Maiden Surname): Mary Smith

19a. Informant's Name/Relationship (Type, Print): Linda Jolly (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1365 Moyer Rd. Annapolis, Md. 21403

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Green Acres

Date: 1/2-98

20c. Location - City or Town, State: Salisbury, Md.

21. Signature of Funeral Service Licensee: ▶ Gladys B. Stewart

22. Name and Address of Facility: Stewart Funeral Home 821 West Rd. Salisbury, Md. 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Chronic obstructive pulmonary disease yrs.

Due to (or as a consequence of):

b. Congestive heart failure yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D29349

29d. Date signed (Month, Day, Year): 12/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 1104 HEALTHWAY DR. SALISBURY MD. 21804 M. Dabbeers

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997

32. Registrar's Signature: ▶ Julia Dawson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

6 months 20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41322

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Otakar M. Krejci

2. Date of Death Month Dey Yaar: December 24, 1997

3. Time of Death: 5:15 pm

4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 089-10-6166

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 82 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 31, 1915

9. Birthplace *(State or Foreign Country)*: New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 8702 Ridge Road

10f. Zip Code: 20817

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Chief Of Czechoslovakian Information Service

16b. Kind of Business/Industry: Voice of America

17. Father's Name *(First, Middle, Last)*: Frank Krejci

18. Mother's Name *(First, Middle, Maiden Surname)*: Rose Nespor

19a. Informant's Name/Relationship *(Type, Print)*: Vera H. Krejci/ Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8702 Ridge Road Bethesda, Maryland 20817

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Gate of Heaven Cemetery — Date: December 29, 1997

20c. Location - City or Town, State: Silver Spring,Maryland

21. Signature of Funeral Service Licensee: [signature] M00335

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

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To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Ruptured Abdominal Aortic Aneurysm — Hours

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Coronary Artery Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D 42865

29d. Date signed *(Month, Day, Year)*: December 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard L. Feinberg, M.D. 8218 Wisconsin Avenue Bethesda, Maryland 20814-3107

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

151

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1998

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41323

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Maria Kristofovic

2. Date of Death (Month, Day, Year): December 24, 1997

3. Time of Death: 7:19 AM

4a. Facility Name (If not institution, give street and number): Mariner Health - Kensington

4b. City, Town, or Location of Death: Kensington

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 267-37-9643

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 88 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 12, 1909

9. Birthplace (State or Foreign Country): Slovakia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Gaithersburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 951 Clopper Road #A-3

10f. Zip Code: 20878

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cosmetician

16b. Kind of Business/Industry: Cosmetics

17. Father's Name (First, Middle, Last): Peter Szitnyai

18. Mother's Name (First, Middle, Maiden Surname): Maria Matova

19a. Informant's Name/Relationship (Type, Print): Joseph M. Kristoff (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 951 Clopper Raod #A-3, Gaithersburg, Maryland 20878

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory

Date: 12/24/97

20c. Location - City or Town, State: Alexandria, Virginia

21. Signature of Funeral Service Licensee: Mark A.

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. DIABETES MELLITUS

Due to (or as a consequence of):

c. DIABETIC NEUROPATHY

Due to (or as a consequence of):

d. POST CEREBRO-VASCULAR ACCIDENT

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D15820

29d. Date signed (Month, Day, Year): 12/24/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): HONG LEE MD 3415 GEORGETOWN ST WHEATON MD 20782

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41324

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARGO CATHERINE KINGSTON
2. Date of Death (Month, Day, Year): December 21 1997
3. Time of Death: 1:50 P
4a. Facility Name *(If not institution, give street and number)*: 307 Central Ave.
4b. City, Town, or Location of Death: Ridgely
4c. County of Death: Caroline

Funeral Director

5. Social Security Number: 476-34-0922
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 61 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: January 11, 1936
9. Birthplace *(State or Foreign Country)*: Wisconsin

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: Ridgely
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 307 Central Ave Box 27
10f. Zip Code: 21660
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 | College (1-4or 5+): 1
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Service Representative
16b. Kind of Business/Industry: Fuji

17. Father's Name *(First, Middle, Last)*: Thomas W. Ott
18. Mother's Name *(First, Middle, Maiden Surname)*: Margaret Greib Ott

19a. Informant's Name/Relationship *(Type, Print)*: James R. Kingston/spouse
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 307 Central Ave. Box 27, Ridgely, MD 21660

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ridgely Cemetery | Date: 12/27/97
20c. Location - City or Town, State: Ridgely, MD

21. Signature of Funeral Service Licensee: Hugh C Fleegle
22. Name and Address of Facility: Fleegle & Helfenbein Funeral Home, 106 W. Sunset Ave., Greensboro, MD 21639

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Breast Cancer — 5 yrs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Polymyalgia Rheumatica

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)* | 28b. Time of Injury | M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J Michael Hamilton MD
29c. License number: D25893
29d. Date signed *(Month, Day, Year)*: 30 Dec 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. MICHAEL HAMILTON, MD MEDICAL ONCOLOGY NATIONAL NAVAL MED CTR, BETHESDA MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 02 '98
32. Registrar's Signature: Sharon Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41325

Lillian Laws SS# 219-07-6310

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LILLIAN G. PETERS LAWS
2. Date of Death Month Day Year: December 26, 1997
3. Time of Death: 0910
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 219-07-6310
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): November 20 1919
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: WICOMICO
10c. City, Town or Location: TYASKIN
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3412 WHITEHAVEN RD
10f. Zip Code: 21865-2075
10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 YRS | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): COLDWATER SEAFOOD
16b. Kind of Business/Industry: SEAFOOD

17. Father's Name (First, Middle, Last): L. GARDENER PETERS
18. Mother's Name (First, Middle, Maiden Surname): MARY E JAMES

19a. Informant's Name/Relationship (Type, Print): LOIS PETERS NIECE
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3412 WHITEHAVEN Rd TYASKIN, Md. 21865-2075

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, cremetory or other place): WHITEHAVEN CEMETERY
Date: 1/3/98
20c. Location - City or Town, State: TYASKIN, Md.

21. Signature of Funeral Service Licensee: ▶ [signature] M00416
22. Name and Address of Facility: MESSICK FUNERAL HOME PO BOX 61 BIVALVE, MD 21814

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. (L) CVA c (R) hemiparesis — 18d

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

- SIPIMI
- (R) pneumonia c pleural effusion,
- CHF

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD
29c. License number: D47619
29d. Date signed (Month, Day, Year): 12/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): OSCAR GRATTERS MD 262 Tilghman Rd, Salisbury, MD 21804

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997
32. Registrar's Signature: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

3

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41326

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David Lee Livesay
2. Date of Death (Month, Day, Year): Dec. 28 1997
3. Time of Death: 5 pm
4a. Facility Name (If not Institution, give street and number): River Road near Route 32
4b. City, Town, or Location of Death: Sykesville
4c. County of Death: Howard

Funeral Director

5. Social Security Number: 218-64-3626
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 43 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Nov. 16 1954
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Howard
10c. City, Town or Location: Woodbine
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 14809 Frederick Road
10f. Zip Code: 21797
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mechanic
16b. Kind of Business/Industry: Automotive

17. Father's Name (First, Middle, Last): Calvin Livesay
18. Mother's Name (First, Middle, Maiden Surname): Grace Ruby McPherson

19a. Informant's Name/Relationship (Type, Print): Heather N. Livesay (daughter)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14809 Frederick Rd. Woodbine MD 21797

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Sharon Baptist Cemetery
Date: 12/31/97
20c. Location - City or Town, State: West Friendship MD

21. Signature of Funeral Service Licensee: Brian L Hayes
22. Name and Address of Facility: Haight Funeral Home & Chapel, P.O. Box 195 Sykesville MD 21784

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SHOTGUN WOUND TO CHEST — SECONDS

Due to (or as a consequence of):
b. DEPRESSION — MONTHS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) ROADSIDE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year): DEC 28 97
28b. Time of Injury: 5P M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: SELF INFLICTED SHOTGUN TO CHEST
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): ROADSIDE IN HIS CAR
28f. Location (Street and Number or Rural Route Number, City or Town, State): RIVER ROAD NEAR ROUTE 32

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Patryce A Toye MD Deputy ME
29c. License number: D31473
29d. Date signed (Month, Day, Year): Dec 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): PATRYCE A. TOYE, MD 4565 Hemlock Cone Way Ellicott City MD 21042.

State Registrar

31. Date filed (Month, Day, Yaar): JAN 05 1998
32. Registrar's Signature: Julia Thacker Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41327

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Grant Lewis
2. Date of Death (Month, Day, Year): December 18,1997
3. Time of Death: 5:30 AM
4a. Facility Name (If not institution, give street and number): 9014 Columbine Lane
4b. City, Town, or Location of Death: Upper Marlboro
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 385-09-8670
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec.15,1916
9. Birthplace (State or Foreign Country): Michigan

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince Georges
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 9014 Columbine Lane
10f. Zip Code: 20772
10g. Citizan of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decadant Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Giva Year or Dates: Unknowen
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.): 1 ☐ Yes ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completad): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 2
16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired): Administration
16b. Kind of Business/Industry: Utilities

17. Father's Name (First, Middle, Last): Grant Lewis, Sr.
18. Mother's Name (First, Middle, Malden Surname): Wilda Eva Willis

19a. Informant's Name/Relationship (Type, Print): Pauline K. Lewis
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9014 Columbine Lane Upper Marlboro, Md. 20772

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Comfort Crematory
Data: 123097
20c. Location - City or Town, State: Alexandria Virginia

21. Signeture of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Affordable Funeral Services Dunn Loring, Va. 22027

Brad

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Finel diseesa or condition resulting in death)
a. Multi organ dysfunction
Due to (or as a consequence of):
b. Lung cancer
Sequantially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Dua to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of causa of death? 1 ☐ Yas 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No
26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☑ Residence 8 ☐ Other (Specify)
27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be datarmined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner steted.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: D45630
29d. Data signed (Month, Day, Year): 12/29/97
30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): Arnulfo Bonaventa 6409 S. Crain Hwy, Upper Marlboro, MD 20772

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for usa as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1998
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 97 41328

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William J. Morrissett Jr.
2. Date of Death (Month, Day, Year): December 28 1997
3. Time of Death: 7:50pm
4a. Facility Name *(If not institution, give street and number)*: 811 Fairfield Avenue
4b. City, Town, or Location of Death: Westminister
4c. County of Death: Carroll

Funeral Director

5. Social Security Number: 217-01-5740
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 82 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Aug 9, 1915
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedent

10a. State: Maryland
10b. County: Carroll
10c. City, Town or Location: Sykesville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 4251 Jim Bowers Road
10f. Zip Code: 21784
10g. Citizen of What Country?: United States

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced
12. Was Decedant Evar in U.S. Armed Forces? 1☒Yas 2☐No If Yes, Give Year or Dates: 1944-45
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*
14. Race - American indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completad)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Steamfitter
16b. Kind of Business/Industry: Construction

17. Father's Nama *(First, Middle, Last)*: William J. Morrissett Sr.
18. Mother's Name *(First, Middle, Maiden Surnama)*: Katherine Rial

19a. Informant's Name/Relationship *(Type, Print)*: Sandra L. Noel/Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4251 Jim Bowers Road Sykesville, Maryland 21784

20a. Mathod of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Placa of Disposition *(Name of cematary, crematory or other place)*: Balt. National Cemetery
Date: 1-2-98
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funaral Service Licensee: ▶ Sharon A. Collins-Witzke
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaasa or condition resulting in death)
a. Adenocarcinomen (R) Upper lobe, — 4mos
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury that initiated events resulting in death) Last
b. Due to (or as a consequance of):
c. Dua to (or as a consequance of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Severe Peripheral Vascular Dz.
Asbestosis

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yas 2☐No

25. Was casa referred to medical examiner? 1☐Yas 2☒No

28. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☒Nursing Homa 5☐Residence 8☐Othar *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accidant 3☐Suicida 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at tha time, data and place, and due to the cause(s) and menner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, data and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶
29c. License number: D37949
29d. Data signed *(Month, Day, Year)*: December 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Alexander Brockenbrough 1425 Liberty Rd Suite 208, Eldersburg, MD 21784

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998
32. Registrar's Signature: Julia Anderson Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41329

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Kaitlin Jessica Marchbanks

2. Date of Death Month Day Year: December 30 1997

3. Time of Death: 2:20 PM

4a. Facility Name *(If not institution, give street and number)*: Greater Baltimore Medical Center

4b. City, Town, or Location of Death: Towson

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-51-5215

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)* Yrs.: If Under 1 Year Months: 1 Days: 12 If Under 24 Hrs. Hours: Min.:

8. Date of Birth *(Month, Day, Year)*: Nov 18, 1997

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residance of Decedant

10a. State: Maryland

10b. County: Baltimore

10c. City, Town or Location: Owings Mills

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 9004 Groffs Mills Drive

10f. Zip Code: 21117

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 0 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: N/A

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: Stephen Lee Marchbanks

18. Mother's Name *(First, Middle, Maiden Surname)*: Sarah J. Wright

19a. Informent's Name/Relationship *(Type, Print)*: Sarah Marchbanks/Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9004 Groffs Mills Drive Owings Mills, MD 21117

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Mt. View Cemetery

Data: 1-2-98

20c. Location - City or Town, State: Marriottsville, MD

21. Signature of Funeral Service Licensee: Steven A. Collins-Witzke

22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hydrocephalus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

b. Severe Prematurity

Due to (or as a consequance of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was cesa referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Steven Pearlman

29c. License number: D30206

29d. Date signed *(Month, Day, Year)*: December 31 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven H. Pearlman MD Greater Baltimore Medical Center Baltimore MD 21204 6701 N Charles Street

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998

32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Kaitlin Jessica Marchbanks

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41330

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: George John Mikulskis

2. Date of Death Month December Day 9, Year 1997

3. Time of Death: 6:39 pm

4a. Facility Name *(If not institution, give street and number)*: 2120 Herbert Avenue

4b. City, Town, or Location of Death: Westminster

4c. County of Death: Carroll County

Funeral Director

5. Social Security Number: 072-16-5289

6. Sex: 1☐M 2☐F XX

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 6, 1920

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard County

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☐Yes 2☐No XX

10e. Street and Number: 9653 White Acre Road

10f. Zip Code: 21045

10g. Citizen of What Country?: USA

11. Marital Status: 1☐Never Married 2☐Married 3☐Widowed XX Divorced

12. Was Decedent Ever In U.S. Armed Forces? XX Yes 2☐No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 2 College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: hairdresser

16b. Kind of Business/Industry: hair styling

17. Father's Name *(First, Middle, Last)*: John Mikulskis

18. Mother's Name *(First, Middle, Maiden Surname)*: Letitia McFaddin

19a. Informant's Name/Relationship *(Type, Print)*: Ms. Desiree Fleagle/daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2120 Herbert Avenue, Westminster, Maryland 21157

20a. Method of Disposition: 1☐Burial 2☒Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory

Date: 10DEC97

20c. Location - City or Town, State: Catonsville, MD

21. Signature of Funeral Service Licensee: MO0535

22. Name and Address of Facility: Slack Funeral Home, P.A. Ellicott City, Maryland 21043

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List *only one* cause *on* each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Failure	24hours
Due to (or as a consequence of):	b. Aspiration pneumonia	1week
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Prostate Cancer Stage IV	1year
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic anemia

Anorexia / Cachexia Syndrome

23b. Did tobacco use contribute to the **cause of death?** 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* Daughters Residence.

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jon K. Mumford MD

29c. License number: D30593

29d. Date signed *(Month, Day, Year)*: 1-8-98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jon K. Mumford, MD 2 Knox North Columbia MD 21045

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1998

32. Registrar's Signature: Julia Strickler Randall

DHMH 16 Rev 6/95

10

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

97-7546-039
CMK
MARY ANN MCCLISTER

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 41331

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Dey / Year	3. Time of Death
MARY	ANN	MCCLISTER	DECEMBER 27, 1997	2013PM

4e. Facility Name (If not institution, give street end number)	4b. City, Town, or Location of Death	4c. County of Death
10000 OLD PRINCESS ANNE ROAD	WESTOVER	SOMERSET COUNTY

Funeral Director

5. Social Security Number	8. Sex	7. Age (In yrs. last birthdey)	If Under 1 Yeer: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Dey, Year)	9. Birthplece (State or Foreign Country)
218-38-6043	1☐M 2☒F	57 Yrs.			9/6/40	Ohio

Usuel Residenca of Decedent

10a. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Somerset	Westover	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
10000 Old Princess Anne Road	21871	USA

11. Maritel Status	12. Wes Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.)	14. Race - American Indien, Bleck, White, etc.
1☐Never Married 2☐Married 3☒Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12	---	Homemaker	Domestic

17. Fether's Neme (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Surneme)
John Allen McLaughlin	Marjorie Ruth Barlow

19e. Informent's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Lydia R. Filgueras/Daughter	405A Brookridge Dr., Salisbury, MD 21804

20e. Method of Disposition	20b. Plece of Disposition (Neme of cemetery, crematory or other plece)	Dete	20c. Location - City or Town, Stete
1☐Burial 2☒Cremetion 3☐Removal from Stete 4☐Donetion 5☐Other (Specify)	Salisbury Crematory	12/31/97	Salisbury, MD

21. Signeture of Funerel Service Licensee: J. M. Holloway

22. Neme end Address of Feciliity: Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

		Approximete Interval Between Onset end Deeth
Immediate Cause (Finel diseese or condition resulting in deeth)	e. Arteriosclerotic Cardiovascular Disease	
	Due to (or es e consequence of):	
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in death) Lest	b. Due to (or es e consequenca of):	
	c. Due to (or es e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☒Probably 4☐Unknown

24a. Wes en eutopsy performed?	24b. Were autopsy findings eveileble prior to completion of cause of death?
INSPECTION 1☐Yes 2☒No	1☐Yes 2☐No

25. Wes case referred to medicel exeminer?	26. Plece of Death (Check only one)	
1☒Yes 2☐No	Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA	Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Menner of Deeth	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner es steted.
2☒ **Medical Examiner**: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) end menner steted.

29b. Signeture end title of certifier	29c. License number	29d. Dete signed (Month, Day, Year)
	O.C.M.E.	DECEMBER 30, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)
J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Dey, Year)	32. Registrer's Signeture
JAN 02 1998	Felicia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41332

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: CAROLYN H McDERMOTT

2. Data of Death Month Dey Yaar: December 29, 1997

3. Time of Death: 5:45 AM

4a. Facility Neme *(If not institution, giva street and number)*: 1511 Camden Avenue

4b. City, Town, or Location of Death: Salisbury

4c. County of Death: Wicomico

Funeral Director

5. Social Security Number: 101-20-7270

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 2/6/26

9. Birthplaca *(Stata or Foreign Country)*: New York

Usual Residence of Decedant

10a. Stete: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1511 Camden Avenue

10f. Zip Coda: 21801

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Married 2☐ Marriad 3☒ Widowad 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Giva Yaer or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indian, Black, White, etc. *Specify:* White

15. Dacedant's Education *(Specify only highast grada completed)*: Elementery/Secondery (0-12): 12; Collaga (1-4or 5+): –

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT usa retired)*: Librarian

16b. Kind of Businass/Industry: State of Maryland

17. Fether's Nema *(First, Middle, Last)*: Henry F. Heidegger

18. Mother's Nama *(First, Middle, Maidan Sumama)*: Carrie M. Cristini

19a. Informant's Neme/Relationship *(Type, Print)*: Kathryn Gray/daughter

19b. Mailing Address *(Streat and Number or Rural Route Numbar, City or Town, Stata, Zip Coda)*: 1511 Camden Ave., Salisbury, MD 21801

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stata 4☐ Donetion 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cemetary, cramatory or othar place)*: First Baptist Cemetery

Data: 1/2/98

20c. Location - City or Town, State: Pocomoke City, MD

21. Signature of Funeral Service Licensee: W R Dellinger

22. Nama and Address of Facility: Holloway Funeral HOme 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part1. Entar tha disaase, or complications that caused tha deeth. Do not enter the mode of dying, such es cardiac or raspiratory errast, shock, or haart failura. List only ona causa on aach line.

Approximete Interval Batween Onsat and Deeth

Immediata Cause (Final disaesa or condition resulting in daath): a. Breast Cancer - Metastate — 12yrs

Dua to (or as a consequance of):

Sequantially list conditions, if any, leading to immadieta causa. Entar Underlying Causa (Disease or injury that initiated avents resulting in daeth) Last:

b. Dua to (or as e consequence of):

c. Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to complation of cause of death? 1☐ Yas 2☒ No

25. Was casa referred to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Homa 5☒ Rasidance 6☐ Othar *(Specify)*

27. Manner of Deeth: 1☒ Naturai 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28a. Piece of Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*

28f. Location *(Streat and Number or Rural Routa Number, City or Town, Stete)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowledge, deeth occurred at tha tima, date and piece, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, daath occurred at tha tima, data and place, and due to tha cause(s) and mannar statad.

29b. Signatura and title of certifier: M.D.

29c. Licansa number: H50497

29d. Date signed *(Month, Day, Year)*: 12/31/97

30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print): Christopher Snyder 108 Pine Bluff Rd. Salisbury, MD 21801 410-749-7284

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 02 1998

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41333

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: IDA BENDER MANUEL

2. Date of Death — Month: 12 Day: 28 Year: 97

3. Time of Death: 0149

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 168-20-5420

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 8 21 1908

9. Birthplace *(State or Foreign Country)*: PENNSYLVANIA

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: WICOMICO

10c. City, Town or Location: SALISBURY

10d. Inside City Limits: 1☐ Yes 2☐ No

10e. Street and Number: 830 SHOEMAKER ROAD

10f. Zip Code: 21804

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexicen, Puerto Ricen, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - Americen Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Edcetion *(Specify only highest grade completed)*: Elementery/Secondary (0-12): — College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOMEMAKER

16b. Kind ot Business/Industry: HOMEMAKING

17. Fether's Neme *(First, Middle, Last)*: ALBERT BENDER

18. Mother's Name *(First, Middle, Maiden Surname)*: ELIZABETH STENGLE

19a. Intormant's Name/Relationship *(Type, Print)*: BRUCE A. MANUEL SON

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: P.O. BOX 1086, EXMORE, VA. 23350

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from Stete 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: BELLE HAVEN CEMETERY

Dete: 12/30/97

20c. Location - City or Town, State: BELLE HAVEN, VA.

21. Signature of Fenerel Service Licensee: Henry Daughty

22. Name and Address of Feclility: DOUGHTY FUNERAL HOME, INC. P.O. BOX 633, EXMORE, VA. 23350

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that ceuse the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARREST

Due to (or as a consequence ot):
b. SHOCK — 1 HR.

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest
c. PROBABLE RUPTURED ANEURYSM

Due to (or as a consequence ot):
d.

Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I.: CONGESTIVE HEART FAILURE

23b. Did tobacco use contributa to the ceuse of deeth? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy tindings available prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medicel examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner ot Deeth: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, tarm, street, tactory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best ot my knowledge, death occurred et the time, date and place, and due to the ceuse(s) and manner as stated. 2☐ **Medicat Examiner:** On the basis ot examination and/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) end menner steted.

29b. Signature end title of certitier: Robert Allen M.D.

29c. License number: D29168

29d. Date signed *(Month, Day, Year)*: 12/28/97

30. Name and address ot person who completed ceuse of death (Item 23a) (Type, Print): ROBERT ALLEN MD 560 RIVERSIDE DR #204 SALISBURY, MD 21801

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 02 1998

32. Registrar's Signature: Julia Davidson-Pardell

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

IDA MANUEL 168-20-5420

97 41334

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILHELMINA MCGUIRE			2. DATE OF DEATH (Month, Day, Year): December 28, 1997	3. TIME OF DEATH: 5:30PM
4. SOCIAL SECURITY NUMBER: 359-14-2734	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug 28 1915	8. BIRTHPLACE (State or Foreign Country): Illinois
9a. FACILITY NAME (If not institution, give street and number): Carroll County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Westminster		9c. COUNTY OF DEATH: Carroll
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Sykesville		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1442 Buckhorn Road		10f. ZIP CODE: 21784		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): dental hygienist		16b. KIND OF BUSINESS/INDUSTRY: health care
17. FATHER'S NAME (First, Middle, Last): Frank Bernard Wagner		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Mary Elbus		
19a. INFORMANT'S NAME (Type/Print): Joseph Edward McGuire (son)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7079 MacBeth Way Sykesville, Md. 21784		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Crest Lawn Memorial Gardens DATE: 1-2-98		20c. LOCATION — City or Town, State: Marriottsville Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Brian A. Haight		22. NAME AND ADDRESS OF FACILITY: Haight Funeral Home P.O. Box 195 Sykesville, Md. 21784		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PNEUMONIA	2 DAYS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DEMENTIA	6 MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. CEREBROVASCULAR DISEASE	6 MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Dan H. Schreibfeder MD	028221	▶ December 28, 1997

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAN H. SCHREIBFEDER, MD 200 Memorial Ave., Westminster, MD 21157 CARROLL COUNTY General HOSPITAL

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 05 1998	Julia Davidson Randall

DHMH-16 Rev 1/89

9736000622 UNIT # 21-09-69
MCGUIRE,WILHELMINA
365-A TURNES,PATRICK A
08/28/1915 F 12/26/97
INP

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41335

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Parice Smoot Miller

2. Date of Death (Month, Day, Year): Dec. 31, 1997

3. Time of Death: 8:50 PM

4a. Facility Name (If not institution, give street and number): 13 Rockdale Ave.

4b. City, Town, or Location of Death: Churchville

4c. County of Death: Harford

Funeral Director

5. Social Security Number: 217-26-0902

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 9, 1930

9. Birthplace (State or Foreign Country): North Carolina

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Churchville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13 Rockdale Ave.

10f. Zip Code: 21028

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Seamstress

16b. Kind of Business/Industry: Clothing Manufacturing

17. Father's Name (First, Middle, Last): Walter Harrison Smoot

18. Mother's Name (First, Middle, Maiden Surname): Ila Marietta Burchette

19a. Informant's Name/Relationship (Type, Print): Cathy R. Hinchy/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1616 Castleton RD, Darlington, MD 21034

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Placa of Disposition (Name of cemetery, crematory or other placa): Mt. Zion Methodist Chr. Cem. Date: 1-5-98

20c. Location - City or Town, State: Bel Air, Maryland

21. Signature of Funeral Service Licensee: Charles A. Emge Jr.

22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury RD, Abingdon, MD 21009

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Metastatic Ovarian Carcinoma — 2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D34652

29d. Date signed (Month, Day, Year): January 2, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Scott Haswell 2 North Avenue Bel Air Maryland 21014

State Registrar

31. Date filed (Month, Day, Year): JAN 05 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41336

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Hubert Meenan

2. Date of Death Month December Day 30 Year 1997

3. Time of Death: 6:10 P.M.

4a. Facility Name (If not institution, give street and number): Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 133-22-2848

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 3, 1926

9. Birthplace (State or Foreign Country): Ireland

Usual Residence of Decedent

10a. State: N/A

10b. County: N/A

10c. City, Town or Location: Washington, D. C.

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 725 24th Street N. W.

10f. Zip Code: 20037

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Marketing & Sales

16b. Kind of Business/Industry: Petroleum Industry

17. Father's Name (First, Middle, Last): Henry Meenan

18. Mother's Name (First, Middle, Maiden Surname): Anne O'Neill

19a. Informant's Name/Relationship (Type, Print): Kate Meenan-Waugh - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4889 MacArthur Blvd. NW Washington, D.C. 20007

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Emmitsburg Memorial Cem.

Date: 1/5/98

20c. Location - City or Town, State: Emmitsburg, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Joseph Gawler's Sons 5130 Wisconsin Ave. N.W. Washington, D.C. 20016

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Myocardial Infarction — 24 Hours

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Arteriosclerotic Heart Disease — 10 Years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Abdominal Aortic Aneurysm

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John F. Gustafson, MD

29c. License number: D 15049

29d. Date signed (Month, Day, Year): December 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John F. Gustafson, M. D. 5480 Wisconsin Avenue Chevy Chase, MD 20815

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1998

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41337

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
Blanche Olive Marts	December 29, 1997	4:15 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Manor Care - Kensington	Kensington	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
513-01-2795	1☐ M 2☒ F	78 Yrs.			Nov. 1, 1919	Kansas

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	Prince George's	Camp Springs	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
6002 Middleton Lane	20748	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamantary/Secondary (0-12)	College (1-4or 5+)		
	4	Homemaker	Own Home

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Frank S. McGlade	Ruby Emily Ralston

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Eric Marts (son)	9212 Midwood Road, Silver Spring, MD 20910

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Arlington National Cemetery	1/9/98	Arlington, Virginia

21. Signature of Funeral Service Licensee: Steven D Stynd

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disaase, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failure. List only one ceuse on eech line.

		Approximata Interval Between Onset and Deeth
Immedieta Causa (Final disaese or condition resulting in death)	a. Urosepsis	Days
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leading to immediete causa. Entar Underlying Cause (Disaese or injury thet initieted events resulting in deeth) Lest	b. Progressive Alzheimers Dementia	Years
	Dua to (or as a consaquenca of):	
	c.	
	Due to (or es a consequenca of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were eutopsy findings available prior to completion of cause of daath?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Daath (Check only one)	
1☐ Yas 2☑ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☑ Nursing Home 5☐ Residenca 8☐ Othar (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be datarminad		M	1☐ Yas 2☐ No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Straet and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one): 1☑ **Certifying Physician:** To tha bast of my knowledga, death occurred at tha tima, date and placa, end due to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On the besis of exemination end/or investigation, in my opinion, daath occurred at the time, date and place, and dua to tha causa(s) end menner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
	D36046	1/2/98

30. Name and address of person who completed cause of daath (item 23a) (Type, Print): John J. MERENDINO JR. 4701 Randolph Rd Rockville, MD. 20852

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 05 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41338

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SHIRLEY MARKWOOD
2. Date of Death (Month, Day, Year): Dec. 31, 1997
3. Time of Death: 1:15pm
4a. Facility Name (If not institution, give street and number): Rockville Nursing Home
4b. City, Town, or Location of Death: Rockville
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218-54-9964
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sept. 21, 1903
9. Birthplace (State or Foreign Country): NY

Usual Residence of Decedent

10e. State: MD
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9449 Copenhaver Drive
10f. Zip Code: 20854
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, spacify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): House Wife
16b. Kind of Business/Industry: Own Home

17. Fether's Neme (First, Middle, Last): ISadore Mandell
18. Mother's Name (First, Middle, Meiden Surneme): Dora Gleitzman

19e. Informant's Name/Relationship (Type, Print): Juliet Slavin-Daughter
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 9449 Copenhaver Dr. Potomac, MD 20854

20a. Method of Disposition: 1☒ Buriel 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, cremetory or other pleca): Washington Heb,Cong Mem
Dete: 1/2/98
20c. Location - City or Town, State: Washington, DC

21. Signature of Funeral Service Licensee: -Daniel Simons
22. Name and Address of Fecility: Edward Sagel Funeral Direction 1091 Rockville Pike Rockville, MD 20852

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
e. CEREBROVASCULAR ACCIDENT

Due to (or es e consequenca of):
b. ATHEROSCLEROTIC CARDIOVASCULAR DISEARE

Sequentleily list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Last

Due to (or as e consequenca of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CEREBELLO PONTINE ANGLE TUMOR, DIABETES MELLITUS, CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings availeble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other (Specify)

27. Manner of Deeth: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examinar**: On the basis of exemineticn end/or investigation, in my opinion, deeth occurred at the time, dete and pieca, and due to the cause(s) and menner stated.

29b. Signature and Title of Certifier:
29c. License number: D26571
29d. Date signed (Month, Dey, Year): 1/2/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): IRVING MIZUS, MD 4930 DEL RAY AVE. BETHESDA, MD 20814

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

5

State Registrar

31. Date filed (Month, Dey, Yeer): JAN 05 1998
32. Registrar's Signature: Julia Davidson-Ruppelle

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41339

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THOMAS NAZARETH MAGARIAN, JR.

2. Date of Death Month Day Year: December 27, 1997

3. Time of Death: 7:45 A.M.

4a. Facility Name *(If not institution, give street and number)*: Larkin-Chase Nursing Home

4b. City, Town, or Location of Death: Bowie

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 001-32-8287

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 54 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 13, 1943

9. Birthplace *(State or Foreign Country)*: Massachusetts

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George

10c. City, Town or Location: Mitchellville

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 2002 Bermondsey Drive

10f. Zip Code: 20721

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12; College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Letter Carrier

16b. Kind of Business/Industry: U.S. Postal Service

17. Father's Name *(First, Middle, Last)*: Thomas Nazareth Magarian, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Virginia Tomasian

19a. Informant's Name/Relationship *(Type, Print)*: Lucia A. Magarian - Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2002 Bermondsey Drive, Mitchellville, Maryland 20721

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Fort Lincoln Cemetery

Date: 12-31-97

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: Robert J. Gutheim

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. LUNG CANCER WITH METASTASIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: Mario F. Golle JR MD

29c. License number: D33954

29d. Date signed *(Month, Day, Year)*: DECEMBER 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F. GOLLE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998

32. Registrar's Signature: Julia Davidson-Ponsella

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If Item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41340

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: William H. Miller

2. Date of Death Month Day Year: December 28, 1997

3. Time of Death: 1:20 am

4a. Facility Name *(If not institution, give street and number)*: Montgomery General Hospital

4b. City, Town, or Location of Death: Olney

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-20-8776

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 6, 1914

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 14514 Homecrest Rd.

10f. Zip Code: 20906

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Machinist

16b. Kind of Business/Industry: Dept. of Navy

17. Father's Name *(First, Middle, Last)*: Jacob Miller

18. Mother's Name *(First, Middle, Maiden Surname)*: Sarah Kramer

19a. Informant's Name/Relationship *(Type, Print)*: Paul Miller

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 9520 Duffer Way Gaithersburg, MD 20879

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: King David Mem. Gdns.

Date: 1/2/97

20c. Location - City or Town, State: Falls Church, VA

21. Signature of Funeral Service Licensee: Peter R. Ham

22. Name and Address of Facility: Ives-Pearson Funeral Homes 2847 Wilson Blvd. Arlington, VA 22201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. ACUTE ON CHRONIC RESP. FAILURE — DAYS

Due to (or as a consequence of):
b. PNEUMONIA. — DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
Due to (or as a consequence of):
c. Chronic obstructive lung disease — years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D38457

29d. Date signed *(Month, Day, Year)*: DECEMBER 28, 1997

30. Name and address of person who completed cause of death (Item 23a) *(Type, Print)*: N. COMPLIMS 10117 PRINCE PHILIP DR OLNEY MD 20832

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41341

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): James Albert Murphy
2. Data of Deeth: Month Dec Day 30, Yaar 1997
3. Tima of Death: 6:45 AM
4a. Facility Nama (If not institution, giva straat and number): 603 Marion Quimby Drive
4b. City, Town, or Location of Death: Stevensville
4c. County of Death: Queen Anne

Funeral Director

5. Sociel Security Number: 577 18 4734
6. Sax: 1☐M 2☐F XX
7. Age (In yrs. last birthday): 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb 25, 1908
9. Birthplace (State or Foraign Country): Washington DC

Usual Residance of Decedant

10e. Stata: MD
10b. County: Queen Anne
10c. City, Town or Location: Stevensville
10d. Inside City Limits: 1☐Yas 2☐No XX
10e. Street and Number: 603 Marion Quimby Drive
10f. Zip Coda: 21666
10g. Citizen of What Country?: United States
11. Meritel Status: 1☐Navar Married XXMarriad 3☐Widowad 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2XXNo If Yas, Giva Yaar or Detes:
13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐Yas 2☐XXNo Spacify:
14. Rece - American Indian, Black, White, atc. Specify: White
15. Dacedant's Education (Specify only highast grade completed): Elementary/Secondary (0-12): 8th; Collega (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa ratired): Truck Driver
16b. Kind of Businass/Industry: Crusty Pie Company
17. Fathar's Name (First, Middle, Last): Harry T. Murphy
18. Mother's Name (First, Middla, Maiden Surnama): Grace L. Mothershead
19a. Informant's Name/Ralationship (Type, Print): Carita E. Murphy
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda): 603 Marion Quimby Drive, Stevensville, Md 21666
20a. Mathod of Disposition: XXBurial 2☐Cramation 3☐Removal from Stata 4☐Donation 5☐Othar (Spacify)
20b. Place of Disposition (Name of cematary, crametory or othar place): Washington National Cemetery — Date: Jan 3, 1998
20c. Location - City or Town, Stata: Suitland, Maryland
21. Signeture of Funeral Service Licensee: ▶ [signature]
22. Nama and Addrass of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one causa on aach lina.

Approximate Interval Between Onsat and Death

Immedieta Causa (Final disaasa or condition resulting in daath)
a. LIVER CANCER — > 1 year

Due to (or as a consequence of):

Sequantially list conditions, if any, leading to immediata causa. Entar Underlying Causa (Disaasa or injury that initiated evants resulting in death) Last
b.
Due to (or as a consequance of):
c.
Due to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa givan in Part I.

23b. **Did tobacco use contributa to the cause of death?** 1☐Yes 2XNo 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2XNo

24b. Wara autopsy findings available prior to completion of causa of death? 1☐Yas 2XNo

25. Was casa refarrad to medical examinar? 1☐Yas 2XNo

26. Placa of Daath (Chack only one) — Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA — Othar: 4☐Nursing Homa 5XResidance 6☐Othar (Specify)

27. Mannar of Death: 1XNatural 2☐Accidant 3☐Suicida 4☐Homicida 5☐Pending Investigation 6☐Could not be determined

28a. Data of Injury (Month, Day Year)
28b. Tima of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Dascribe how injury occurred
28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Spacify)
28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one): 1XCertifying Physician: To the best of my knowledge, death occurred at tha time, data and place, and dua to tha causa(s) and mannar as stated. 2☐Medical Examinar: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the causa(s) and menner statad.

29b. Signature and title of certifier: ▶ Helen A Noble MD
29c. License number: D41587
29d. Data signed (Month, Day, Year): 12/31/97

30. Name and address of parson who compliatad causa of death (Item 23a) (Type, Print): HELEN A NOBLE MD 122 SPEER RD. CHESTERTOWN, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 0 8 1998
32. Registrar's Signatura: [signature]

DHMH 16 Rav 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41342

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
MYRNA		NOTTINGHAM	12	26	97	1345

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
PENINSULA REGIONAL MEDICAL CENTER	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
230-60-7508	1☐ M 2☒ F	46 Yrs.					5-14-51	Virginia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Va.		Virginia Beach	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
607 Red Horse Rd.	23462	U. S. A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
	2	Adm. Assistant	University

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Matthew Nottingham	Mary Felton Nottingham Burton

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mary Burton mother	Eastville, Virginia

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Union Bap.	12-29-97	Eastville, Va.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Keith Edgar Wharton	Wharton Funeral Home Accomac, Va. 23301 P.O Box 97

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS-INSULIN DEPENDENT

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
John T. Bulkeley D.M.E.	D03599	12-27-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN T. BULKELEY, M.D., 108 PINE BLUFF ROAD, SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 05 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41343

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LORETTA Anna NOBBS

2. Data of Death Month/Day/Year: DECEMBER 29 1997

3. Time of Death: 10:15 PM

4a. Facility Name *(If not institution, give street and number)*: 314 Waysons Drive

4b. City, Town, or Location of Death: Lothian

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 175 22 7906

6. Sex: 1☐ M XX F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: June 22, 1929

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Lothian

10d. Inside City Limits: 1☐ Yes 2☐ No XX

10e. Street and Number: 314 Waysons Drive

10f. Zip Code: 20754

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3 XX Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2 XX No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Cafateria Worker

16b. Kind of Business/Industry: P.G. Schools

17. Father's Name *(First, Middle, Last)*: Daniel Patrick Cairns

18. Mother's Name *(First, Middle, Maiden Surname)*: Lillian Marie Kick

19a. Informant's Name/Relationship *(Type, Print)*: Janice Haupt

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3443 C. Hyacinth Place, Waldorf, Maryland 20602

20a. Method of Disposition: 1 XX Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Maryland Veterans Cemetery

Date: Jan 5, 1998

20c. Location - City or Town, State: Cheltenham, Maryland

21. Signature of Funeral Service Licensee: ▶ S. E. Lee

22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRYTHMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Peter Wisniewski

29c. License number: D40370

29d. Date signed *(Month, Day, Year)*: 12/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Peter wisniewski, M.D. 120 Hsopital Road, #200, Prince Fredrick, Md 20678

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 1998

32. Registrar's Signature: ▶ [signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41344

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PATRICIA ANN PRICE

2. Date of Death Month / Day / Year: December 30 1997

3. Time of Death: 2356

4a. Facility Name *(If not institution, give street and number)*: Union Hospital

4b. City, Town, or Location of Death: Elkton

4c. County of Death: Cecil

Funeral Director

5. Social Security Number: 213-46-3437

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 52 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Jan. 10, 1945

9. Birthplace *(State or Foreign Country)*: Tennessee

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Abingdon

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1222 Bush Road

10f. Zip Code: 21009

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Emory (NMN) Sturgill

18. Mother's Name *(First, Middle, Maiden Surname)*: Mildred Blanche Mullens

19a. Informant's Name/Relationship *(Type, Print)*: Howard W. Price, Jr./Husband

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1222 Bush Road, Abingdon, MD 21009

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Harford Memorial Gardens

Date: 1/3/98

20c. Location - City or Town, State: Aberdeen, Maryland

21. Signature of Funeral Service Licensee: Charles A. Emge J

22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. CAD

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

PVD

INSULIN DEPENDENT DIABETIC

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D 22195

29d. Date signed *(Month, Day, Year)*: 1/2/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

PRICE, PATRICIA CAS

2

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998

32. Registrar's Signature: Joan Thurston-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41345

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DONALD Lee PUTMAN
2. Date of Death (Month, Day, Year): DECEMBER 30 1997
3. Time of Death: 2150
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 462-66-3752
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 53 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): April 26, 1944
9. Birthplace (State or Foreign Country): Texas

Usual Residence of Decedent

10a. State: Virginia
10b. County: Fairfax
10c. City, Town or Location: Great Falls
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 636 River Bend Road
10f. Zip Code: 22066
10g. Citizen of Whel Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Scientist
16b. Kind of Business/Industry: Bio Science

17. Father's Name (First, Middle, Last): Harry Putman
18. Mother's Name (First, Middle, Maiden Surname): Evelyn Lieberman

19a. Informant's Name/Relationship (Type, Print): Elizabeth A. Putman/ Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 636 River BEnd Road, Great Falls, Va. 22066

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Columbia Gardens Cemetery
Date: 1/3/98
20c. Location - City or Town, State: Arlington, Va.

21. Signature of Funeral Servica Licansee: ▶ William Jay Keathley
22. Name and Address of Facility: MONEY & KING VIENNA FUNERAL HOME, INC. 171 W. Maple Ave., Vienna, Va. 22180

BRW

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. METASTATIC COLON CARCINOMA — 2 YEARS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in deeth) Last:
b.
Due to (or as a consequence of):
c.
Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Place of Deeth (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) and menner stated.
29b. Signature and title of certifier: ▶ James G. Brown MD
29c. License number: D07285
29d. Date signed (Month, Day, Year): DECEMBER 30, 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JAMES A. BROWN, MD 9707 Medical Center DR #300 Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1998
32. Registrar's Signature: Julia Davidson-Randall

30

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41346

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Harold Popkin
2. Date of Death (Month, Dey, Yeer): Dec. 31, 1997
3. Time of Death: 10:46am
4e. Facility Name *(If not institution, give street end number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-22-6518
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 71 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: June 4, 1926
9. Birthplace *(State or Foreign Country)*: New York

Usuel Residence of Decedent

10e. Stete: MD
10b. County: Montgomery
10c. City, Town or Location: Rockville
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 4909 McCall Street
10f. Zip Code: 20853
10g. Citizen of Whet Country?: USA

11. Maritel Stetus: 1 [ ] Never Merried 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yeer or Dates: 1944-45
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indien, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12 / College (1-4or 5+):
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Budget Analyst
16b. Kind of Business/Industry: Government

17. Fether's Name *(First, Middle, Last)*: Morris Popkin
18. Mother's Name *(First, Middle, Meiden Surneme)*: Rose Pilnick

19e. Informent's Neme/Relationship *(Type, Print)*: Alice Popkin-spouse
19b. Mailing Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 4909 McCall Street Rockville, MD 20853

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Judean Memorial Gardens
Dete: 1/2/98
20c. Location - City or Town, Stete: Olney, MD

21. Signature of Funeral Service licensee: -Daniel Simons
22. Neme end Address of Feciity: Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852

Physician /Medical Examiner

23e. Pert I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiratory errest, shock, or heert failure. List only one ceuse on eech line. — Approximate Interval Between Onset and Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth)
e. VENTRICULAR TACHYCARDIA

Due to (or as e consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest
b. ISCHEMIC CARDIOMYOPATHY

Due to (or es e consequence of):
c. HYPERTENSION

Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospitel: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end pleca, end due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the besis of examination and/or investigation, In my opinion, death occurred et the time, date and place, and due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier:
29c. License number: D16495
29d. Dete signed *(Month, Dey, Yeer)*: 12/31/97

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): JOEL GOOZH MD 4701 RANDOLPH RD Rockville MD 20852

State Registrar

31. Date filed *(Month, Dey, Yeer)*: JAN 05 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Dec 31, 1997 10:46am

HAROLD POPKIN

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41347

Certificate of Death

Reg. No.

AGNES PAYNE

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AGNES L. PAYNE
2. Date of Death (Month, Day, Year): DEC 31 1997
3. Time of Death: 11:05 AM
4a. Facility Name (If not institution, give street and number): THE MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: EASTON
4c. County of Death: TALBOT

Funeral Director

5. Social Security Number: 220-16-9952
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 07/21/23
9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Caroline
10c. City, Town or Location: Preston
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 5820 Bell Creek Road
10f. Zip Code: 21655
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Arthur Fluharty
18. Mother's Name (First, Middle, Maiden Surname): Mary Patrick

19a. Informant's Name/Relationship (Type, Print): Reese C. Payne/Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5860 Bell Creek Rd., Preston, MD 21655

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Junior Order Cem. | Date: 1/3/98
20c. Location - City or Town, State: Preston, Maryland

21. Signature of Funeral Service Licensee: ▶ Michael F. Eskew
22. Name and Address of Facility: Framptom-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cerebrovascular accident	5 days
	Due to (or as a consequence of):	
	b. Sepsis	5 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D0051132
29d. Date signed (Month, Day, Year): 12-31-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Abrego (JORGE ABREGO MD) 332 N. MAIN ST FEDERALSBURG, MD 21632

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed (Month, Day, Year): JAN 02 '98
32. Registrar's Signature: [signature] Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend #20b, 1/5/98, BMW, Montg. Co

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41348
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Yaar	3. Time of Death
Frances	Weems	Royston	December	30,	1997	5:20 PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Montgomery General Hospital	Olney	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
705-01-6457	1☐ M 2☒ F	90 Yrs.					February 20, 1907	Georgia

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐ Yas 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizan of What Country?
3701 International Drive, #229	20906	United States

11. Marital Status	12. Was Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Navar Married 2☐ Married 3☒ Widowad 4☐ Divorced	1☐ Yas 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decadent's Education (Specify only highest grade completed)		16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired)	16b. Kind of Business/Industry
Elementery/Secondery (0-12)	College (1-4or 5+)		
12		Administrative Officer	United States Government

17. Fathar's Nama (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
James Cleveland Weems	Sarah Evalina Johnson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Barbara R. Bowen / daughter	9817 Kentsdale Drive, Potomac, Maryland 20854

20a. Method of Disposition	20b. Piece of Disposition (Name of cametery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Other (Specify)	Montgomery Crematorium, Inc.	January 3, ~~1997~~ 1998	Bethesda, Maryland

21. Signature of Funeral Service Licansea		22. Name and Address of Facility
Barbara J. McMullen Lawrence	M00831	Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

BMW

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Stroke	3 days
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yas 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Othar (Specify)

27. Manner of Death	28a. Data of Injury (Month, Day Yaar)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined			1☐ Yes 2☐ No	
	28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Howard D. Chazin	D42937	December 30, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
Howard D. Chazin, M.D. 18111 Prince Philip Drive, Olney, MD 20832

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signature
JAN 05 1998	Joyce Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41349
Reg. No.

Spornick, Lynna
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Lynna SPORNICK
2. Date of Death (Month, Day, Year): DECEMBER 30, 1997
3. Time of Death: 8:55AM
4a. Facility Name (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER
4b. City, Town, or Location of Death: TOWSON
4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 149-38-4273
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 6, 1947
9. Birthplace (State or Foreign Country): New York

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Howard
10c. City, Town or Location: Columbia
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 9510 Dragonclaw
10f. Zip Code: 21046
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Physicist
16b. Kind of Business/Industry: Johns Hopkins Applied Physics Lab
17. Father's Name (First, Middle, Last): Louis Kanney
18. Mother's Name (First, Middle, Maiden Surname): Jean Schwartz
19a. Informant's Name/Relationship (Type, Print): Virgil Alexander Spornick/Spouse
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9510 Dragonclaw Columbia, Maryland 21046
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): Balt-Washington Crematory
Date: 12-31-97
20c. Location - City or Town, State: Laurel, Maryland
21. Signature of Funeral Service Licensee: ▶ Donna A. Collins-White
22. Name and Address of Facility: Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD 21043

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. metastatic ovarian Cancer - to brain — 1 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Michael T. Scheerer
29c. License number: D24567
29d. Date signed (Month, Day, Year): 12/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael T. Scheerer M.D. 6569 N. Charles St. Suite 601-Balto.

State Registrar

31. Date filed (Month, Day, Year): JAN 05 1998
32. Registrar's Signature: Julia Davidson-Randall

To be completed by Physician/Medical Examiner: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

30

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41350

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): CALVIN JAMES SMITH

2. Date of Death (Month, Day, Year): DECEMBER 28, 1997

3. Time of Death: 2205

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 214-28-3308

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 70 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 3/13/27

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Wicomico

10c. City, Town or Location: Salisbury

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 310 Calvin Drive

10f. Zip Code: 21804

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: Army

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+): -

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Vendor

16b. Kind of Business/Industry: Potato Chip Co.

17. Father's Name (First, Middle, Last): James Smith

18. Mother's Name (First, Middle, Maiden Surname): Daisey Crouch

19a. Informant's Name/Relationship (Type, Print): Willow Mae Smith/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 310 Calvin Dr., Salisbury, MD 21804

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): Wicomico Memorial Park | Date: 1/2/98

20c. Location - City or Town, State: Salisbury, MD

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: Holloway Funeral Home, 501 Snow Hill Rd., Salisbury, MD 21804

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Ventricular Fibrillation

Due to (or as a consequence of):
b. Coronary Artery Disease

Due to (or as a consequence of):
c. Ischemic Cardiomyopathy

Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D40715

29d. Date signed (Month, Day, Year): 12/28/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Steven E. Hearne, MD 400 Eastern Shore Dr. Salisbury, Md. 21804

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998

32. Registrar's Signature: Julia Henderson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Calvin SM. TH 214-28-3308

8/1/VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41351

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Frances Louise Seek

2. Date of Death (Month, Day, Year): December 31, 1997

3. Time of Death: 11:45 AM

4a. Facility Name *(If not institution, give street and number)*: 321 University Boulevard West, Apt. 317

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 215-26-0722

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 69 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug. 25, 1928

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 321 University Blvd. West, Apt. 317

10f. Zip Code: 20901

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: James Elmer Gingell

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Helen Bailey

19a. Informant's Name/Relationship *(Type, Print)*: Barbara A. Tierney (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6256 Taliaferro Way, Kingstowne, VA 22315

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematory

Date: 1/4/98

20c. Location - City or Town, State: Alexandria, VA

21. Signature of Funeral Service Licensee: ▶ William J Byl

22. Name and Address of Facility: Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardio Pulmonary Arrest

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease. — Few weeks to few months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d. Multiple Sclerosis.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Ummanke M.D

29c. License number: D29816

29d. Date signed *(Month, Day, Year)*: January 1, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): RADHEY MURAZKA Rockville MD 50 West Edmonston Drive

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 97 41352

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ROLAND RYAN TWIGG

2. Data of Death Month Day Yaar: December 30, 1997

3. Tima of Death: 0640

4a. Facility Nama *(If not institution, giva straat and numbar)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Numbar: 218-16-8316

6. Sax: 1☒ M 2☐ F

7. Aga *(In yrs. last birthday)*: 72 Yrs.

If Undar 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: 8/14/25

9. Birthplaca *(Stata or Foreign Country)*: Maryland

Usual Rasidance of Dacedant

10a. Stata: Maryland

10b. County: Wicomico

10c. City, Town or Location: Delmar

10d. Insida City Limits: 1☐ Yas 2☐ No

10e. Street and Numbar: Philadelphia Ave.

10f. Zip Coda: 21875

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Marriad 2☐ Marriad 3☐ Widowad 4☒ Divorcad

12. Was Dacedant Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No. If Yas, Giva Yaar or Datas: WW II

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* White

15. Decedent's Education *(Spacify only highast grada complatad)*: Elamantary/Secondary (0-12): 12; Collaga (1-4or 5+): -

16a. Dacedant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Broadcaster

16b. Kind of Businass/Industry: Radio

17. Fathar's Nama *(First, Middla, Last)*: Roland Twigg

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Florence Taylor

19a. Informant's Name/Ralationship *(Typa, Print)*: Virginia J. Twigg/Ex-wife

19b. Mailing Address *(Street and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda)*: 402 Woodview Sq., Apt. D., Salisbury, MD 21804

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Spacify)*

20b. Place of Disposition *(Nama of camatary, cramatory or othar placa)*: Springhill Mamory Gardens

Data: 1/2/98

20c. Locatlon - City or Town, Stata: Hebron, MD

21. Signatura of Funaral Sarvica Licansaa: [signature]

22. Nama and Addrass of Facility: Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21804

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused the death. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Death

Immadiata Causa (Final disaasa or condition rasulting in daath)

a. Parkinson's Disease — 15-20yrs

Dua to (or as a consaquanca of):

Saquantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last

b.

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

Pneumonia with MRSA COPD, Essential HTN - HCV, OSA CVA Capernoma - in Situ Stomach

23b. **Did tobacco usa contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings availabla prior to complation of causa of daath? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☑ No

26. Placa of Daath *(Chack only ona)*: Hospital: 1☑ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidanca 6☐ Othar *(Spacify)*

27. Manner of Death: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurrad

28a. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Spacify)*

28f. Location *(Street and Numbar or Rural Routa Numbar, City or Town, Stata)*

29a. Certifiar *(Chack only ona)*: 1☑ **Certifying Phyaician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar statad.

29b. Signatura and title of certifiar: [signature] M.D.

29c. Licansa number: D57670

29d. Data signed *(Month, Day, Year)*: 12/30/97

30. Nama and addrass of parson who completad causa of daath (Item 23a) (Type, Print): M. L. M. Evangelista 107 Pine Bluff Road #4 Salisbury, MD

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the daath certificate be axacutad within 24 hours after death.

To the Funaral Director: After this certificate has been signed by the attending physician and completely filled in by the funaral director, page 2 should be datachad for use as the burial-transit

Roland Twigg

2+IVA

State Registrar

31. Data filed *(Month, Day, Yaar)*: JAN 02 1998

32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41353

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
RICHARD	LEE	TEAMAN	12	31	97	2310

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1402 S. SALISBURY BLVD	SALISBURY	WICOMICO

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
206-28-3385	1☒ M 2☐ F	60 Yrs.					08-21-37	PENNSYLVANIA

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	WICOMICO	SALISBURY	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1402 S. SALISBURY BLVD.	21801	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☒ Yas 2☐ No If Yas, Give Yeer or Datas: NAVY	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12		CONTRACTOR	SELF EMPLOYED

17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)		
RUELL	RUSSELL	TEAMAN	ESTHER	BEATRICE	BRYANT

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
DEBRA A. FEATHER - DAUGHTER	5133 AIRPORT RD. SALISBURY, MD 21804

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	MD VETERAN'S CEMETERY	1-7-98	HURLOCK, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ B. Keith Phipps, CFSP	BOUNDS FUNERAL HOME 705 E. MAIN ST. SALISBURY, MD 21804

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiratory arrast, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)
e. SEIZURE DISORDER

Due to (or es a consequence of):

Sequantielly list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest

b.

Due to (or es e consequance of):

c.

Dua to (or es a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Wes case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yas 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Homa 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Netural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☐ **Certifying Physician:** To tha best of my knowledge, deeth occurred et tha time, date and place, and due to the cause(s) and menner es stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daeth occurred et the time, date and place, and due to the cause(s) and menner steted.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ D.M.E.	H50497	1-2-98

30. Neme and eddress of parson who completed cause of death (item 23a) (Type, Print)
CHRISTOPHER S. SNYDER, D.O., 108 PINE BLUFF ROAD, SALISBURY MD 21801

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 05 1998	▶ Julia Sheridan Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

To the Hospital or Attending Physician: Tha law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

1st VA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41354

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDWARD F. THORNTON

2. Date of Death Month: December Day: 30, Year: 1997

3. Time of Death: 4:30 P.M.

4a. Facility Name *(If not institution, give street and number)*: 3315 Sackertown Road

4b. City, Town, or Location of Death: Crisfield

4c. County of Death: Somerset

Funeral Director

5. Social Security Number: 213-22-7844

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: June 23, 1904

9. Birthplace *(State or Foreign Country)*: Indiana

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Somerset | 10c. City, Town or Location: Crisfield | 10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 3315 Sackertown Road | 10f. Zip Code: 21817 | 10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): Grade 2 | College (1-4or 5+): - - -

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: General Contractor

16b. Kind of Business/Industry: Demolition

17. Father's Name *(First, Middle, Last)*: Frank Thornton

18. Mother's Name *(First, Middle, Maiden Surname)*: Dora Gable

19a. Informant's Name/Relationship *(Type, Print)*: Lillian Louise Wilson (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: Rt. 2 - Box 176X - Laurel, DE 19956

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, cremetory or other place)*: Asbury Cemetery | Date: 1/3/98

20c. Location - City or Town, State: Crisfield, MD

21. Signature of Funeral Service Licensee: Robert H. Bradshaw, Jr.

22. Name and Address of Facility: Bradshaw & Sons Funeral Home, 306 W. Main St.- Crisfield, MD 21817

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death) e. Chronic Obstructive Lung Disease years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypertension

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Ronald P. Travitz

29c. License number: D36576

29d. Date signed *(Month, Day, Year)*: 1/2/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ronald P. Travitz, M.D. - 560 Riverside Dr.- Suite A-204- Salisbury, MD 21801

State Registrar

31. Date filed *(Month, Day, Year)*: JAN - 8 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41355

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ruth Virginia Thomas

2. Date of Death Month Day Year: Dec 29, 1997

3. Time of Death: 7:35 AM

4a. Facility Name *(If not institution, giva street and number)*: 1907 Billings Ave

4b. City, Town, or Location of Death: Capitol Heights

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 210-07-9976

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Yeer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: Jan 27, 1912

9. Birthpleca *(Stata or Foreign Country)*: Pa.

Usual Residence of Decedent

10e. Stete: MD

10b. County: Prince George's

10c. City, Town or Location: Capitol Heights

10d. Inside City Limits: 1☐ Yes 2☒ No XX

10e. Street and Number: 1907 Billings Ave

10f. Zip Code: 20743

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Marriad 2☐ Married XX Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes XX No If Yas, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas XX No Specify:

14. Race - Amarican Indien, Bleck, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12): 12 / College (1-4or 5+):

16e. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Own Home

17. Fethar's Neme *(First, Middle, Last)*: Clement Chettle

18. Mother's Neme *(First, Middle, Malden Surneme)*: Catheren Frobe

19e. Informent's Neme/Reletionship *(Type, Print)*: Mr. Thomas C. Thomas (SON)

19b. Melling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 1907 Billings Ave, Capitol Heights, MD 20743

20e. Method of Disposition: XX Buriel 2☐ Cremetion 3☐ Remavel from Stata 4☐ Donetion 5☐ Other *(Specify)*

20b. Place of Disposition *(Nema of cemetery, crametory or other place)*: Cedar Hill Cemetery Date: Jan 2, 1998

20c. Location - City or Town, Steta: Suitland , Maryland

21. Signature of Funerel Servica Licensee: ▶ Sth E. Sith

22. Name end Address of Facility: Lee Funeral Home,Inc 6633 Old Alexandira Ferry Road, Clinton,Md 20735

Physician /Medical Examiner

23a. Pert1. Enter the disaase, or complicetions that causad tha death. Do not entar tha moda of dying, such es cerdiac or respiretory errest, shock, or heart failure. List only one cause on eech line.

Approximete Intervel Between Onsat and Deeth

Immedlete Ceuse (Finel diseesa or condition resulting in death) e. Sepsis — 7-10 Days

Due to (or es e consequence of):

Sequentially list conditions, if eny, leading to immedlete cause. Enter Underlying Ceuse (Diseese or Injury thet Initieted events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. **Other significant conditione** contributing to death but not resulting in the underlying ceuse given in Part I.: Decubitus ulcers

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy parformed? 1☐ Yas 2☒ No

24b. Were eutopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes cese referred to medicet exeminer? 1☐ Yes 2☒ No

26. Plece of Death *(Check only one)*: Hospitel: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☑ Residence 8☐ Other *(Specify)* With Hospice.

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete and plece, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier: ▶ MD

29c. License number: D42580.

29d. Date signed *(Month, Dey, Year)*: 12-31-97

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): PARMJIT SINGH AHUJA MD 5632 Annapolis Rd. Bladens Burg MD 20710 #13

State Registrar

31. Deta filed *(Month, Dey, Yeer)*: JAN 0 8 1998

32. Registrer's Signeture: Julie Strecker Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97-7407-045
B.K.S

KESHIA WARNER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41356

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: KESHIA DeSHe"' WARNER
2. Date of Death (Month, Day, Year): DEC. 22, 1997
3. Time of Death: 1803 PM

4e. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL HOSPITAL
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 219-19-3038
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 11 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): APR. 26, 86
9. Birthplace *(State or Foreign Country)*: CAMBRIDGE

Usual Residence of Decedent

10e. State: MD.
10b. County: WICOMICO
10c. City, Town or Location: SALISBURY
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 424 WASHINGTON STREET
10f. Zip Code: 21801
10g. Citizen of What Country?: USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* AFRO-AMERICAN

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6th | College (1-4or 5+)
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: STUDENT
16b. Kind of Business/Industry: STUDENT

17. Father's Name *(First, Middle, Last)*: TONY WARNER
18. Mother's Name *(First, Middle, Maiden Surname)*: VANESSA JONES

19a. Informant's Name/Relationship *(Type, Print)*: TONY WARNER
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: ADDRESS SAME AS ABOVE

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: SPRINGHILL MEMORY GARDEN | Date: 12-27
20c. Location - City or Town, State: HEBRON, MD.

21. Signature of Funeral Service Licensee: Loretta B. Jolley
22. Name and Address of Facility: JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD; SALISBURY, MD. 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hanging
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 12/22/97
28b. Time of Injury: UNK M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how Injury occurred: Subject hanged self
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: AT HOME
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 424 Washington ST, 21801

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature] M.D.
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Year)*: DEC. 23, 1997
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): J. LARSON LOCKE MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

2

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41357

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wellington Webb
2. Date of Death: Month December Day 24 Year 1997
3. Time of Death: 12:45 PM
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 528-14-8759
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Yaar: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 31 1917
9. Birthplace (State or Foreign Country): Utah

Usual Residence of Decedent

10a. State: Virginia
10b. County: Fairfax
10c. City, Town or Location: Great Falls
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1272 Kenmore Drive
10f. Zip Code: 22066
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Nevar Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Evar in U.S. Armad Forces? 1 [X] Yes 2 [ ] No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired): Furniture Manufacture
16b. Kind of Business/Industry: Furniture

17. Father's Name (First, Middle, Last): Archibald George Henry Webb
18. Mother's Name (First, Middle, Maiden Surneme): Margaret Thompson

19a. Informant's Name/Relationship (Type, Print): Mary Margaret Drasbek(Daughter)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 1272 Kenmore Drive Great Falls, Va. 22066

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Nema of cemetery, crematory or other piece): Salt Lake City Cemetery
Date: 010298
20c. Location - City or Town, State: Saltlake City, Utah

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Affordable Funeral Services 2230 Gallows Road #110 Dunn Loring, Va. 22027

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not anter fhe mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona cause on each line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)
a. Acute Myocardial Infarction — Minutes

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.: Pancreatic Carcinoma

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Panding Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Phyafcian:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as atated. 2 [ ] **Medicaf Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier: [signature], MD
29c. License number: D 33261
29d. Date signed (Month, Day, Year): December 24, 1997

30. Name and address of person who completad cause of death (Item 23a) (Type, Print): 9901 Medical Center Drive Rockville, Md. 20850

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97-7499-031
UNK. 97-280

B.K.S MATTHEW TODD WOLFF

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41358

Physician /Medical Examiner

1. Decedant's Name (First, Middle, Last): Matthew Todd Wolff
2. Date of Death (Month, Day, Year): December 27, 1997
3. Time of Death: 0325
4a. Facility Name (If not institution, give street and number): RIVER ROAD AND TACK HOUSE COURT
4b. City, Town, or Location of Death: POTOMAC
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 487-80-2627
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 22 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth (Month, Day, Year): January 5, 1975
9. Birthplace (State or Foreign Country): Missouri

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Gaithersburg
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 13428 Query Mill Road
10f. Zip Code: 20878
10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4or 5+): 3
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student
16b. Kind of Business/Industry: College

17. Father's Name (First, Middle, Last): Bruce William Wolff
18. Mother's Name (First, Middle, Maidan Surname): Barbara Shea

19a. Informant's Name/Relationship (Type, Print): Bruce W. Wolff/Father
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13428 Query Mill Road, Gaithersburg, Maryland 20878

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or othar piece): Montgomery Crematorium, Inc. Date: January 1, 1998
20c. Location - City or Town, State: Bethesda, Maryland

21. Signeture of Funeral Service Licensee: Michael A. Higgins M00846
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/Rockville, Inc, 300 West Montgomery Avenue, Rockville, Maryland 20814-2805

Physician /Medical Examiner

23a. Part I. Enter tha disaase, or complications that causad tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only ona cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Smoke Inhalation and Burn Injuries	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yas 2☐ No
24b. Were eutopsy findings availabie prior to completion of cause of death? 1☒ Yas 2☐ No

25. Wes case referred to medical axaminer? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residance 6☒ Other (Specify) ROADWAY

27. Manner of Death: 1☐ Netural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Data of Injury (Month, Day Year): DEC. 27, 1997
28b. Time of Injury: 0312 M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how injury occurred: DRIVER IN AUTO ACCIDENT; CAR ERUPTED INTO FLAMES
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET
28f. Location (Street and Number or Rural Route Number, City or Town, State): RIVER ROAD AND TACK HOUSE CT.

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as steted. 2☒ **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and menner stated.
29b. Signature and title of certifier: J. LaRon Locke MD
29c. License number: OCME
29d. Date signed (Month, Day, Year): 12-27-97
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): J. LARon LOCKE, MD 111 Penn St. Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 05 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41359

Physician /Medical Examiner

Funeral Director

1. Decedent's Name *(First, Middle, Last)*: Charles Worley

2. Date of Death Month Day Year: December 31, 1997

3. Time of Death: 3:45 AM

4a. Facility Name *(If not institution, give street end number)*: Holy Cross Hospital

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

5. Social Security Number: 479-38-7076

6. Sex: XX 1 M 2 F

7. Age *(In yrs. last birthday)* Yrs.: 62

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 22 1935

9. Birthplace *(State or Foreign Country)*: Iowa

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 1008 Downs Drive

10f. Zip Code: 20904

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yas, Give Year or Detes:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decadent's Education *(Specify only highast grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Astronomer

16b. Kind of Business/Industry: Naval Observatory/Gov't

17. Father's Name *(First, Middle, Last)*: Charles Worley

18. Mother's Neme *(First, Middle, Maiden Sumeme)*: Iona Cooney

19a. Informant's Name/Reletionship *(Type, Print)*: Jane Worley/Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1008 Downs Drive, Silver Spring, Md. 20904

20a. Method of Disposition: 1 ☐ Buriel 2 XX Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Othar *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other piece)*: Fort Lincoln Crematory

Dete: 1/6/98

20c. Location - City or Town, State: Brentwood, Maryland

21. Signatura of Funaral Sarvice Licensee: [signature]

22. Name and Address of Facility: Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, Md. 20904

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death)

a. Sepsis

Due to (or es e consequence of):

b. chronic alcohol abuse

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest

Due to (or aa a consequence of):

c. chronic ulcers

Due to (or aa a consequence of):

d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uae contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes en autopsy performed? 1 ☒ Yes 2 ☐ No

24b. Were autopsy findings availeble prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ Ne

26. Place of Death *(Check only one)*: ICU

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other *(Specify)*

27. Menner of Deeth: 1 ☒ Naturel 2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending invastigation 6 ☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time ot Injury M

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Phyalcian:** To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date end placa, and due to the cause(s) and menner steted.

29b. Signature and title of certifier: [signature] 2696

29c. Licansa number: D52191

29d. Date signed *(Month, Dey, Year)*: JANUARY 1, 1998

30. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print): Esteban A. Marquez MD Holy Cross Hospital

State Registrar

31. Date filed *(Month, Dey, Year)*: JAN 05 1998

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41360

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES L. ARTIS, SR.

2. Date of Death (Month, Day, Year): DECEMBER 30, 1997

3. Time of Death: 3:30 P.M.

4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 231-40-4578

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB 22, 1936

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 12201 Duley Station Rd.

10f. Zip Code: 20772

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): General Contractor

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Thomas Artis

18. Mother's Name (First, Middle, Malden Surname): Anna Everett

19a. Informant's Name/Relationship (Type, Print): Jo Ann Artis / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12201 Duley Station Rd.,Upper Marlboro, Md 20772

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery

Date: 1/3/98

20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: ▶ Alex S Pope M859

22. Name and Address of Facility: ALEXANDER S. POPE FUNERAL HOMES 5538 Marlboro Pike, Forestville, Md. 20747

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Hemorrhagic Infarction, Brain — weeks

Due to (or as a consequence of):

b. Hypertension — years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D30318

29d. Date signed (Month, Day, Year): 12/31/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James Catakeos 3001 Hospital Dr Cheverly MD 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 05 1998

32. Registrar's Signature: Gabi Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41361

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Wilma Brown

2. Date of Death: Month 12 Day 29 Year 97

3. Time of Death: 0208

4a. Facility Name (If not institution, give street and number): 8765 JarWood Road

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 286-34-5488

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 76 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): October 16, 1921

9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Ohio

10b. County: Stark County

10c. City, Town or Location: Massillon

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 638 Guy Street, N.W.

10f. Zip Code: 44647

10g. Citizen of What Country? United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Joseph Mitzel

18. Mother's Name (First, Middle, Maiden Surname): Maud Spencer

19a. Informant's Name/Relationship (Type, Print): Shirley Autrey /Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8765 Jar Wood Road, Baltimore, Maryland 21237

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Saint Barbara's Cemetery

Date: January 3, 1998

20c. Location - City or Town, State: Massillon, Ohio

21. Signature of Funeral Service Licensee #M00690: Howard A Causer

22. Name and Address of Facility: Arnold-Lynch Funeral Home, 729 Lincoln Way, East, Massillon, Ohio 44646

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Acute myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic ischemic myocardial disease — 5 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: J. Crossan Donovan, M.D.

29c. License number: DO 7632

29d. Date signed (Month, Day, Year): DEC 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. CROSSAN O'DONOVAN, M.D., 2112 DUNDALK AVE., BALTO MD 21222

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41362

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

1. Decedent's Neme (First, Middle, Last): Neal Behm
2. Dete of Death (Month, Dey, Yeer): December 30, 1997
3. Time of Death: 1:30 PM
4a. Facility Neme (If not institution, give street and number): VETERANS ADMINISTRATION MEDICAL CENTER
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A
5. Sociel Security Number: 280-40-7277
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthdey): 53 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): AUG. 19, 1944
9. Birthplece (Stete or Foreign Country): OHIO

Usuel Residence of Decedent

10e. Stete: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: GLEN BURNIE
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street and Number: 1012 PHILLIP DRIVE
10f. Zip Code: 21061
10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☒Yes 2☐No If Yes, Give Yeer or Detes: 1964-1975
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Rican, etc.): 1☐Yes 2☒No Specify:
14. Race - American Indien, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): ANALYSIS
16b. Kind of Business/Industry: FEDERAL GOVERNMENT

17. Fether's Neme (First, Middle, Last): HAROLD BEHM
18. Mother's Neme (First, Middle, Meiden Surname): MILDRED RUPPLE

19e. Informent's Neme/Reletionship (Type, Print): CATHERINE ROSE BEHM (WIFE)
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 1012 PHILLIP DRIVE, GLEN BURNIE, MD. 21061

20e. Method of Disposition: 1☒Burieł 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): MD. VETERANS CEMETERY
Dete: 1/5/98
20c. Locetion - City or Town, Stete: CROWNSVILLE, MD.

21. Signeture of Funerel Service Licensee:
22. Neme end Address of Feciliity: SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heart failure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in deeth): e. Metastatic Squameous Cell cancer of — 7 months
Due to (or es a consequence of): Head and Neek

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last:
b. Due to (or es e consequence of):
c. Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

unrepaired left hip fracture, on 1/1/97, left neck mass, Decubitus ulcers, possible spinal cord compression

23b. Did tobecco use contribute to the cause of death?: 1☑Yes 2☐No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed?: 1☐Yes 2☑No
24b. Were eutopsy findings available prior to completion of cause of death?: 1☐Yes 2☐No

25. Wes cese referred to medicel exeminer?: 1☐Yes 2☑No
26. Piece of Deeth (Check only one): Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☑Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Deeth: 1☑Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined
26a. Dete of Injury (Month, Dey Yeer):
28b. Time of Injury: M
28c. Injury at Work?: 1☐Yes 2☐No
28d. Describe how injury occurred:
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify):
28f. Locetion (Street and Number or Rurel Route Number, City or Town, Stete):

29e. Certifier (Check only one): 1☑**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐**Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Perry Colvin MD
29c. License number: D32548
29d. Dete signed (Month, Dey, Yeer): December 30, 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): PERRY COLVIN, MD 10 N. Greene Street, Baltimore

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 06 1998
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41363

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARY P BRAY

2. Date of Death: Month December Day 30 Year 1997

3. Time of Death: 2:00 P.M.

4a. Facility Name (If not institution, give street and number): Magnolia Gardens Center

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 170-14-8750

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 93 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 16, 1904

9. Birthplace (State or Foreign Country): Eckman, West Virginia

Usual Residence of Decedent

10a. State: Maryland | 10b. County: Prince George's | 10c. City, Town or Location: Upper Marlboro | 10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 325 Alastair Street | 10f. Zip Code: 20774 | 10g. Citizen of What Country? United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorcad

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): George Green

18. Mother's Name (First, Middle, Melden Surneme): Eliza Jane Lee

19a. Informant's Name/Relationship (Type, Print): Marlene Murphy/ Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 325 Alastair Street, Upper Marlboro, MD 20774

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Horn Cemetery | Date: January 3, 1998

20c. Location - City or Town, State: West Bethlehem Twp Pennsylvania

21. Signature of Funeral Servica Licansee #M00690: ▶ Howard Carson

22. Name and Address of Facility: Nichol Funeral Home 1873 East Maiden Street, Washington, PA 15301

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Congestive heart failure	2 years
	Due to (or as a consequence of):	
	b. Sepsis & pneumonia	2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year) | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) | 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) end manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Rointan Farahifar M.D.

29c. License number: D43446

29d. Date signed (Month, Day, Year): 12/30/97

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): ROINTAN FARAHIFAR M.D. 4000 Mitchellville road B216 Bowie MD 20716

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41364

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mae C. Baten
2. Date of Death: Month 12 Day 29 Year 97
3. Time of Death: 3:09 pm
4a. Facility Name *(If not institution, give street and number)*: Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 577-52-3788
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 60 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 12/15/37
9. Birthplace *(State or Foreign Country)*: Wash DC

Usual Residence of Decedent

10a. State: DC
10b. County:
10c. City, Town or Location: Washington
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 615 Atlantic Street SE
10f. Zip Code: 20032
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Nursing Assistant
16b. Kind of Business/Industry: Hospital

17. Father's Name *(First, Middle, Last)*: James Brooks
18. Mother's Name *(First, Middle, Maiden Surname)*: Arlie Fletcher

19a. Informant's Name/Relationship *(Type, Print)*: Angela Gibson
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 924 Southern Ave SE Wash DC 20020

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Harmony Memorial Park — Date: 1/3/98
20c. Location - City or Town, State: Landover MD

21. Signature of Funeral Service Licensee: Robert A. Smith
22. Name and Address of Facility: Robert G. Mason Funeral Home, 1661 Good Hope Rd SE, Washington DC 20020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Sepsis	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Recurrent kidney infection 2° to kidney stone	
	Due to (or as a consequence of):	
	c. DIC	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient (ICU) 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: 2696
29c. License number: D52191
29d. Date signed *(Month, Day, Year)*: JAN 6, 1998

30. Name and address of person who completed cause of death (item 23e) (Type, Print): Marquez Esteban MD Holy Cross Hospital Kaiser Office

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41365

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Norma Jane Canter

2. Date of Death Month Day Year: December 30 1997

3. Time of Death: 8:45PM

4a. Facility Name *(If not institution, give street and number)*: 602 Edwards Road

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 271-28-9763

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 67 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept 17 1930

9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 602 Edwards Road

10f. Zip Code: 21401

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Home

17. Father's Name *(First, Middle, Last)*: Felix DeMolli

18. Mother's Name *(First, Middle, Maiden Surname)*: Anna Grossoni

19a. Informant's Name/Relationship *(Type, Print)*: Thomas S. Canter (Husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 602 Edwards Road Annapolis, Maryland 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hillcrest Memorial Cemetery Date: 1/5/98

20c. Location - City or Town, State: Annapolis, Maryland

21. Signature of Funeral Service Licensee: ▶ Brian J. Clyne

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. myocardial infarction — Immediate

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. respiratory muscle paralysis — Immediate

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: amyotrophic lateral sclerosis

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Ira E Kaplan MD

29c. License number: D25611

29d. Date signed *(Month, Day, Year)*: 1/7/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Ira E. Kaplan, M.D. 7845 Oakwood Road #300 Glen Burnie, Maryland 21061

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1998

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH t6 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41366

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Joseph P Donoghue

2. Date of Death Month Day Year: December 31, 1997

3. Time of Death: 11:46 P

4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death: ROCKVILLE

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 119-24-2687

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 19, 1932

9. Birthplace *(State or Foreign Country)*: New York, NY

Usual Residence of Decedent

10a. State: N.Y.

10b. County: Richmond

10c. City, Town or Location: Staten Island

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 188 Brighton Street

10f. Zip Code: 10307

10g. Citizen of What Country?: United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yeer or Dates: 1951-1955

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) / College (1-4or 5+): -2-

16a. Decedent's Usual Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Senior Systems Analyst

16b. Kind of Business/Industry: NYNEX

17. Fether's Name *(First, Middle, Last)*: John Donoghue

18. Mother's Name *(First, Middle, Maiden Surneme)*: Agnes Towey

19a. Informent's Neme/Relationship *(Type, Print)*: Joseph E. Donoghue - Son

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 24004 Preakness Drive Damascus, Maryland 20872

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Resurrection Cemetery

Dete: 1/5/98

20c. Location - City or Town, Stete: Staten Island, NY

21. Signeture of Funeral Service Licensee #M00690: Howard Dawson

22. Name end Address of Facility: J.W. Bedell Funeral Home 7447 Amboy Road, Statten Island, New York, 10307

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heart feilure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediate Ceuse (Final diseese or condition resulting in death)

e. ACUTE MYOCARDIAL INFARCTION — MINUTES

Due to (or es a consequenca of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last

b. CORONARY ARTERY DISEASE — YEARS

Due to (or es a consequenca of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveilable prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☒ Yes 2☐ No

26. Piece of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred et the time, date and piece, and due to the ceuse(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: M.D.

29c. License number: D37024

29d. Date signed *(Month, Day, Year)*: December 31, 1997

30. Name end address of person who completed cause of death (Item 23e) (Type, Print): DAVID G. SHAW, M.D. 9901 Medical Center Drive Rockville, MD. 20850

State Registrar

31. Date filed *(Month, Dey, Yeer)*: JAN 08 1998

32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41367

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BURRELL EDMONDS

2. Data of Death — Month: December Day: 28 Year: 1997

3. Time of Death: 6:15pm

4a. Facility Name *(If not institution, giva street and number)*: PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: P.G.

Funeral Director

5. Social Security Number: 577-26-0233

6. Sex: 1☒ M 2☐ F

7. Aga *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 6-14-23

9. Birthplace *(Stata or Foraign Country)*: WASH. D.C.

Usual Residance of Decadant

10a. State: D.C.

10b. County:

10c. City, Town or Location: WASHINGTON, D.C.

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 331 34th PL. N.E.

10f. Zip Coda: 20019

10g. Citizan of What Country?: U.S.A.

11. Marital Stetus: 1☐ Navar Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decadant Ever in U.S. Armed Forcas? 1☒ Yas 2☐ No If Yes, Giva Yaar or Datas:

13. Was Dacadant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Ricen, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* BLACK

15. Decadant's Education *(Specify only highast grada completed)*: Elamantary/Secondary (0-12): 12 / Collaga (1-4or 5+):

16a. Decadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: CAB DRIVER

16b. Kind of Businass/Industry: PRIVATE

17. Fathar's Nama *(First, Middla, Last)*: WILLIS EDMONDS

18. Mothar's Nama *(First, Middla, Maiden Surname)*: NOT STATED

19a. Informant's Name/Ralationship *(Type, Print)*: MATTIE T. EDMONDS/WIFE

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 331 34th PL. N.E. WASH. D.C. 20019

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cemetery, crematory or othar placa)*: HARMONY MEMORIAL PARK

Data: 1-3-98

20c. Location - City or Town, Steta: LANDOVER, MD.

21. Signature of Funeral Servica Licansa: John Watson Jr.

22. Nama and Address of Facility: WATSON FUNERAL HOME 3435 14th ST. N.W. WASH. D.C. 20010

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiena. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter tha disaasa, or complications that causad tha daath. Do not antar tha mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach line.

Approximata Intarval Batween Onsat and Death

Immediata Causa (Final disaasa or condition rasulting in daath)

a. INTRACEREBRAL BLEED

Dua to (or as a consequance of):

b. THROMBOLYTIC THERAPY

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiatad avants rasulting in daath) Last

Dua to (or es e consequance of):

c. ACUTE INFERIOR WALL MYOCARDIAL INFARCTION

Dua to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: HYPERTENSION.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Wara autopsy findings available prior to complation of causa of daath? 1☐ Yas 2☐ No

25. Was casa raferred to medical examiner? 1☐ Yas 2☑ No

26. Placa of Death *(Check only ona)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Home 5☐ Rasidanca 6☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Route Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifiar *(Check only one)*: 1☑ **Cartifying Physician:** To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as statad. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurrad at tha time, data and placa, and dua to the cause(s) and mannar statad.

29b. Signature and title of certifier: [signature], MD

29c. Licansa number: D31089

29d. Dete signed *(Month, Day, Year)*: December 28, 1997

30. Nama and address of parson who complatad causa of daath (Item 23a) (Type, Print): MORRIS JUTCOVICH - 8201 Corporate Drive Suite 620 Landover, MD 20785

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(10)

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 06 1998

32. Registrar's Signatura: John Thurston Randall

DHMH 16 Rav 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 41368

Item:11 per FH G-756 2/9/98 dh

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Nellie Josephine Flaherty

2. Date of Death Month Day Year: December 28,1997

3. Time of Death: 6:06 A.M.

4a. Facility Name *(If not institution, give street end number)*: Garrett County Hospital

4b. City, Town, or Location of Death: Oakland

4c. County of Death: Garrett

Funeral Director

5. Social Security Number: 577-07-9817

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)* Yrs.: 90

If Under 1 Yaar: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: August 28,1907

9. Birthplace *(State or Foraign Country)*: Maryland

Usual Residence of Decedant

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Oxon Hill

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street end Number: 7308 Cloverdale Drive

10f. Zip Coda: 20745

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☒ Navar Marriad 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedant Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yas, Giva Year or Detes:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decadant's Education *(Specify only highast grada completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT use ratired)*: Secretary

16b. Kind of Businass/Industry: Banking

17. Fathar's Nama *(First, Middla, Last)*: James T. Flaherty

18. Mothar's Name *(First, Middle, Maidan Surnama)*: Nellie J. Lawler

19a. Informant's Name/Ralationship *(Type, Print)*: James P. Collins,Sr./Nephew

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 7308 Cloverdale Drive, Oxon Hill, Md.20745

20a. Mathod of Disposition: 1☒ Burial 2☐ Cremation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cemetery, crametory or othar place)*: St. Ignatius Church Cem. Data: 12/31/97

20c. Location - City or Town, Stata: Ft.Washington, Md.

21. Signature of Funaral Sarvice Licensee: George P. Kalas

22. Nama and Address of Facility: George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md.20745

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one causa on each lina.

Approximata Interval Batwaen Onsat and Death

Immediata Causa (Final disaasa or condition resulting in death): a. Cerebral Vascular Accident

Due to (or as a consequence of):

Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or Injury that initiated avants resulting in daath) Last:

b.

Due to (or as a consaquance of):

c.

Due to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Wara autopsy findings available prior to completion of causa of daath? 1☐ Yas 2☐ No

25. Was case rafarred to madical exeminar? 1☐ Yas 2☑ No

26. Placa of Death *(Check only one)*: Hospital: 1☑ Inpatiant 2☐ ER/Outpatiant 3☐ DOA Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar *(Specify)*

27. Manner of Death: 1☑ Naturel 2☐ Accident 3☐ Suicida 4☐ Homicida 5☐ Pending Invastigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated. 2☐ **Medical Examinar:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and mannar stated.

29b. Signatura and title of certifier: Paul Daniel Miller, M.D.

29c. License number: #26154

29d. Date signed *(Month, Day, Year)*: 12/28/97

30. Nama and address of person who completed causa of daath (Item 23a) (Type, Print): Paul Daniel Miller, M.D. 69 Wolf Acres Dr., Oakland, Md. 21550

State Registrar

31. Data filed *(Month, Day, Yaar)*: JAN 07 1998

32. Registrar's Signature: Judith Gardner Rudell

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

(5)

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41369

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Margaret Fox

2. Date of Death — Month: December; Day: 22; Year: 1997

3. Time of Death: 10:15 AM

4a. Facility Neme (If not institution, give street and number): 12212 CROSS ROAD TRAIL

4b. City, Town, or Location of Death: BRANDYWINE

4c. County of Deeth: PRINCE GEORGE'S

Funeral Director

5. Sociel Security Number: 577-03-1386

6. Sex: 1☐M 2☒F

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Year): JUNE 10, 1913

9. Birthplace (Stete or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. Stete: MARYLAND

10b. County: PRINCE GEORGE'S

10c. City, Town or Location: BRANDYWINE

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street end Number: 12212 CROSS ROAD TRAIL

10f. Zip Code: 20613

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorcad

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Reca - American Indian, Bleck, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grede completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): HOMEMAKER

16b. Kind of Business/Industry: OWNED HOME

17. Fether's Name (First, Middle, Last): JOSEPH WILHELM

18. Mother's Name (First, Middle, Maiden Surneme): MARY MOZINGO

19a. Informent's Name/Relationship (Type, Print): MARGARET M. LEDSON, DAUGHTER

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 12212 CROSS ROAD TRAIL, BRANDYWINE, MD 20613

20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): FORT LINCOLN CEMETERY

Dete: 12/24/97

20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: Louis L. Grant

22. Name and Address of Facility: FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line.

Approximate Intervel Between Onset and Deeth

Immediate Cause (Finel disease or condition resulting in death)

a. CONGESTIVE HEART FAIUVRE — 5 YRS.

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest

b. CORONARY ARTERY DISEASE

Due to (or es e consequence of):

c. HIGH BLOOD PRESSURE

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Dfd tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was en eutopsy performed? 1☐Yes 2☒No

24b. Were sutopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No

26. Place of Death (Check only one): Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 8☐Other (Specify)

27. Menner of Deeth: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28e. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how Injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) end manner as stated. 2☐**Medical Examiner:** On the basis of examination end/or investigetion, In my opinion, deeth occurred at the time, date and pleca, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: [illegible]

29c. License number: D-34498

29d. Date signed (Month, Dey, Year): DECEMBER 30, 1997

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print): HENRY RENNY DE LA BAUME 7700 OLD BRANCH, AVE. CLINTON MD

State Registrar

31. Date filed (Month, Day, Yeer): JAN 05 1998

32. Registrar's Signeture: Sylvia Thurston-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminer must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended # 2. Per Doctor P.G.C. 1-13-98 cr

Certificate of Death

Reg. No. 97 41370

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MILLIE JACKSON FARMER

2. Data of Death — Month: December — Day: 24 — Year: 1997

3. Time of Death: 1:00 P.M.

4a. Facility Name (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 218-26-3343

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): Jan. 16, 1916

9. Birthplace (State or Foreign Country): Midland, VA

Usual Residence of Decedent

10a. State: District of Columbia

10b. County:

10c. City, Town or Location: Washington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 4346 Martin L. King, Jr. Ave., S. W.

10f. Zip Code: 20032

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 9th — College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Joseph Jackson

18. Mother's Name (First, Middle, Maiden Surname): Millie Washington

19a. Informant's Name/Relationship (Type, Print): Harry C. Farmer, Jr. - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4346 Martin L. King, Jr. Ave.,S.W.,Wash., D.C. 20032

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park — Date: 12/30/97

20c. Location - City or Town, State: Landover, MD

21. Signature of Funeral Service Licensee: John T. Stewart III

22. Name and Address of Facility: STEWART FUNERAL HOME, Inc. 4001 Benning Road, N.E.,Washington, D. C.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerotic Heart Disease — 12/22/97.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last: b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Nephrosclerosis.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 8☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rakesh Arora, MD

29c. License number: D20108

29d. Date signed (Month, Day, Year): 12/24/97.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rakesh Arora, M.D., 14300 Gallant Fox Lane, Suite 222, Bowie, MD 20715

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997

32. Registrar's Signature: John Hunter Rankin

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

AMENDED # 20c. P.G.C. 1/8/98cr

Certificate of Death

Reg. No. 97 41371

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CLARENCE GROSS

2. Data of Death — Month: DECEMBER; Dey: 31; Yaar: 1997

3. Time of Death: 02:32AM

4a. Facility Neme *(If not institution, giva straat and number)*: PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 578 40 1490

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthdey)*: 66 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: 8/4/31

9. Birthplace *(Stata or Foreign Country)*: WASHINGTON, DC

Usual Residance of Decedant

10a. Stata: MD

10b. County: PRINCE GEORGE'S

10c. City, Town or Location: CAPITAL HEIGHTS

10d. Inside City Limits: 1 ☒ Yas 2 ☐ No

10e. Street and Number: 1001 UTEWAY ST.

10f. Zip Coda: 20743

10g. Citizen of Whet Country?: USA

11. Marital Stetus: 1 ☒ Nevar Marriad 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Dacedant Evar in U.S. Armed Forcas? 1 ☒ Yas 2 ☐ No — If Yas, Giva Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuben, Maxican, Puarto Rican, atc.): 1 ☐ Yas 2 ☒ No *Specify:*

14. Race - Amarican Indien, Black, Whita, atc. *Specify:* BLACK

15. Decedant's Education *(Specify only highast grada compliated)*: Elamentary/Secondary (0-12): 12 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: Maintenance Supervisor

16b. Kind of Business/Industry: DC Government

17. Father's Name *(First, Middla, Last)*: CLARENCE JOSEPH GROSS SR.

18. Mothar's Nama *(First, Middle, Malden Surneme)*: HELEN SMITH

19a. Informant's Name/Ralationship *(Type, Print)*: ELIZA WEST / COMMON LAW WIFE

19b. Mailing Addrass *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Code)*: 1001 UTEWAY ST. CAPITAL HEIGHTS, MD 20743

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Ramoval from Stata 4 ☐ Donetion 5 ☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematery, cramatory or othar place)*: Cheltenham Cemetery

Dete: 1/9/98

20c. Location - City or Town, Steta: Cheltenham ~~Brandywine~~ MD

21. Signature of Funeral Service Licensee: [signature]

22. Name end Address of Facility: ROBERT G. MASON FUNERAL HOME 1661 GOOD HOPE RD. SE. WASHINGTON, DC 20020

Physician /Medical Examiner

23a. Part1. Entar the disaasa, or complications that causad tha death. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximate Intarval Batween Onsat and Death

Immediate Cause (Final disaasa or condition rasulting in daath)
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequanca of):

Sequentially list conditions, if eny, leading to immadiata cause. Enter Underlying Cause (Diseasa or Injury thet initietad evants rasulting in daath) Last
b.

Due to (or as a consequence of):
c.

Due to (or as e consequanca of):
d.

Part ti. **Other significant conditions** contributing to death but not rasulting in tha underlying causa givan in Part I.

23b. Did tobacco use contributa to the causa of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was en autopsy performed? 1 ☐ Yas 2 ☒ No

24b. Ware autopsy findings available prior to completion of cause of deeth? 1 ☐ Yas 2 ☐ No

25. Was casa referred to medical examinar? 1 ☒ Yes 2 ☐ No

26. Placa of Deeth *(Check only one)*: Hospital: 1 ☐ Inpatiant 2 ☒ ER/Outpatient 3 ☐ DOA — Othar: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar *(Specify)*

27. Mannar of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Placa of injury - At homa, farm, street, factory, offica building, atc. *(Specify)*

28b. Tima of Injury: M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1 ☐ **Certifying Physician**: To the best of my knowledge, death occurred at the tima, dete and placa, and dua to the causa(s) and mannar as stated. 2 ☒ **Medical Examinar**: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifiar: [signature] MD PME

29c. Licansa number: D33954

29d. Data signed *(Month, Day, Year)*: JANUARY 4, 1998

30. Nema end address of parson who completed causa of death (Item 23a) (Type, Print): MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 07 1998

32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41372

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Francis Ginty
2. Date of Death Month: 12 Day: 31 Year: 97
3. Time of Death: 4:33 p.m.
4a. Facility Name *(If not institution, give street and number)*: Anne Arundel Medical Center
4b. City, Town, or Location of Death: Annapolis
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 045-20-7057
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 69 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: June 20 1928
9. Birthplace *(State or Foreign Country)*: Connecticut

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 906 Topmast Way
10f. Zip Code: 21401
10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yes, Give Year or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No *Spacify:*
14. Race - American indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondery (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Claim Supervisor
16b. Kind of Business/Industry: Insurance

17. Father's Name *(First, Middle, Last)*: Patrick Ginty
18. Mother's Name *(First, Middle, Maiden Surname)*: Mary Keane

19a. Informant's Name/Relationship *(Type, Print)*: Aileen Ginty (Wife)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 906 Topmast Way Annapolis, Maryland 21401

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: St. Peter Cemetery — Date: Jan. 3 1998
20c. Location - City or Town, State: Danbury Connecticut

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line. — Approximata Interval Between Onset and Death

Immediate Cause (Finel disaase or condition resulting in death)
a. Ventricular Tachycardia Arrest
Due to (or as a consequence of):
b. Cardiomyopathy (Dilated)

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in daath) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yas 2 ☒ No
26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be datarmined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Streat and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] M.D
29c. License number: D51560
29d. Date aigned *(Month, Day, Year)*: 12/31/97

30. Neme end eddress of person who completed cause of death (Item 23a) (Type, Print): Grant R. Simms, M.D. 2003 Medical Parkway Annapolis, MD 21401

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1998
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41373

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Evelyn Mae Henderson
2. Date of Death Month Day Year: Dec. 25, 1997
3. Time of Death: 11:20 PM
4a. Facility Name *(If not institution, give street and number)*: Physicians Memorial Hospital
4b. City, Town, or Location of Death: La Plata
4c. County of Death: Charles

Funeral Director

5. Social Security Number: 217-10-4721
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 89 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 14, 1908
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Saint Mary's
10c. City, Town or Location: Mechanicsville
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 26931 Tin Top School Road
10f. Zip Code: 20659
10g. Citizen of What Country?: United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Humphrey D. T. Lehman
18. Mother's Name *(First, Middle, Meiden Surneme)*: Mary Lucinda Harden

19a. Informant's Name/Relationship *(Type, Print)*: Joanna M. Gantt/ Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 26931 Tin Top School Road, Mechanicsville, MD 20659

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hyndman Cemetery
Date: December 29, 1997
20c. Location - City or Town, State: Hyndman, Pennsylvania

21. Signature of Funeral Service Licensee: Karen W. Grove
22. Neme end Address of Facility: Harvey H. Zeigler Funeral Home P.O. Box 636 Hyndman, PA 15545

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARCINOMATOSIS — UNK

Due to (or as a consequence of):
b. I

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ANEMIA

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Medicat Examiner:** On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Joel Sewchand MD
29c. License number: D-29646
29d. Date signed *(Month, Day, Year)*: 12-26-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Sewchand, Joel, MD Medical Arts Center 3600 Leonardtown RD.#103 Waldorf, MD. 20601

State Registrar

31. Date filed *(Month, Day, Year)*: 12-JAN 02 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Evelyn Henderson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41374

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: SHAYTON J. HERNDON

2. Data of Death Month Day Yaar: DEC. 31 1997

3. Tima of Death: 10:00 pm

4a. Facility Nama *(If not institution, giva street and number)*: ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Deeth: ANNAPOLIS

4c. County of Daeth: ANNE ARUNDEL

Funeral Director

5. Social Security Numbar: 220-84-4114

6. Sex: 1 ☒ M 2 ☐ F

7. Aga *(In yrs. last birthday)*: 22 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: JULY 8 1975

9. Birthplaca *(State or Foreign Country)*: MARYLAND

Usual Rasidanca of Decadant

10a. Stata: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ANNAPOLIS

10d. Insida City Limits: 1 ☒ Yas 2 ☐ No

10e. Street end Number: 1852 BOWMAN COURT

10f. Zip Code: 21401

10g. Citizan of What Country?: US

11. Marital Status: 1 ☒ Nevar Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorcad

12. Was Dacedant Evar in U.S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Give Year or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- if Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ Yas 2 ☒ No *Specify:*

14. Race - Amarican Indian, Black, Whita, atc. *Specify:* BLACK

15. Dacedant's Education *(Spacify only highast grada complatad)*: Elementary/Secondary (0-12): 10th; Collega (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratired)*: LABORER

16b. Kind of Business/Industry: GARRISSON CONTRACTORS

17. Fether's Nama *(First, Middla, Last)*: JOHN L. HERNDON

18. Mother's Nema *(First, Middla, Maiden Sumama)*: MARY A. DAVIS

19a. Informant's Neme/Ratationship *(Type, Print)*: MARY A. DAVIS (MOTHER)

19b. Mailing Address *(Street and Number or Rural Routa Numbar, City or Town, State, Zip Code)*: 1852 BOWMAN COURT ANNAPOLIS, MD. 21401

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar *(Spacify)*

20b. Placa of Disposition *(Nama of cemetery, cramatory or othar placa)*: ANNAPOLIS MEM. GARDENS

Data: 1/8/97

20c. Location - City or Town, Stata: ANNAPOLIS, MD.

21. Signatura of Funeral Sarvice Licansaa: Harry D. Reese

22. Nama and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on aach lina.

Approximate Intarval Batween Onsat and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. Respiratory

Dua to (or as a consequence of):

b. STATUS Asthmaticus

Saquantially list conditions, if any, leading to immadiata causa. Enter Underlying Ceuse (Disaasa or injury that initiated events resulting in death) Last

Dua to (or as a consaquanca of):

c.

Dua to (or as a consequenca of):

d.

Part ii. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part i.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yas 2 ☑ No

24b. Wara autopsy findings available prior to compiation of causa of deeth? 1 ☐ Yas 2 ☐ No

25. Was casa rafarred to medical examiner? 1 ☐ Yes 2 ☐ No

26. Placa of Death *(Check only one)*: Hospital: 1 ☐ Inpatiant 2 ☑ ER/Outpatient 3 ☐ DOA; Othar: 4 ☐ Nursing Homa 5 ☐ Rasidance 6 ☐ Other *(Specify)*

27. Mannar of Death: 1 ☑ Naturai 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding Investigation 6 ☐ Could not be determined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Dascribe how injury occurred

28a. Place of injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifiar *(Check only one)*: 1 ☑ **Certifying Physician:** To tha best of my knowledga, death occurred at the time, data and place, and dua to tha causa(s) and mannar as stated. 2 ☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and placa, and dua to tha causa(s) and manner stated.

29b. Signatura and title of certifiar: Richard A. Bern

29c. Licansa number: D33049

29d. Date signed *(Month, Day, Year)*: 12/31/97

30. Nama and address of parson who compiated causa of daath (Item 23a) (Type, Print): Richard A. Bernstein 600 Ridgely Ave #121 Annapolis md 21401

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

WRC
97-7538-033
JOHN FREDERICK
HEDGES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41375

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
John F. Hedges	DECEMBER 29, 1997	1:13 PM.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
8707 CHERRY LANE	LAUREL	Prince George's

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
066-40-9501	1 [X] M 2 [ ] F	35 Yrs.			Feb. 21, 1962	Ithaca, NY

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
VA	Fairfax	McLean	1 [X] Yes 2 [ ] No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
8350 Greensboro Drive	22102	United States of America

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
-12-		Salesman	Music Store

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Robert B. Hedges	Barbara Wilcox

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Janine McFall - Sister	P.O. Box 961 Trumansburg, NY 14886

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Metropolitan Crematory	December 31, 1997	Alexandria, Virginia

21. Signature of Funeral Service Licensee: Karen W. Rose

22. Name and Address of Facility: Bangs Funeral Home, 209 W. Green Street Ithaca, New York

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Carbon Monoxide Intoxication

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 [X] Yes 2 [ ] No	1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 [X] Yes 2 [ ] No	Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) AT SCENE

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of injury	28c. Injury at Work?	28d. Describe how injury occurred
1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	UNK	UNK M	1 [ ] Yes 2 [X] No	Subject inhaled exhaust fumes

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): IN CAR

28f. Location (Street and Number or Rural Route Number, City or Town, State): 8707 Cherry Lane Laurel, MD

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
James Locke MD	O.C.M.E.	DECEMBER 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
JAMES LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 08 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 41376

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ada Harris

2. Date of Death Month Day Year: December 29, 1997

3. Time of Death: 11:00AM

4a. Facility Name *(If not institution, give street and number)*: 10500 Lake Arbor Way

4b. City, Town, or Location of Death: Mitchellville

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 242-24-2993

6. Sex: 1☐M 2☒F

7. Age *(In yrs. last birthday)*: 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Mar. 27, 1915

9. Birthplace *(State or Foreign Country)*: N. Carolina

Usual Residence of Decedent

10a. State: Md.

10b. County: Prince Georges

10c. City, Town or Location: Bowie

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 14400 Dunstable Court

10f. Zip Code: 20721

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1☐Yes 2☒No If Yas, Giva Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondery (0-12) | College (1-4or 5+): 6 yrs.

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Supervisor

16b. Kind of Business/Industry: Government

17. Fathar's Name *(First, Middle, Last)*: Joseph Miles

18. Mother's Name *(First, Middle, Maiden Surnama)*: Annie (Unknown)

19a. Informant's Name/Relationship *(Type, Print)*: Gloria Jones (Daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1400 Dunstable Ct., Bowie, Md. 20721

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Name of cemetary, crematory or other place)*: Lincoln Memorial

Date: Jan. 5, 1998

20c. Location - Cify or Town, State: Suitland, Md.

21. Signature of Funeral Service Licensee: [signature]

22. Nama and Address of Facility: Ralph Williams Funeral Service 517 - 11th Street, S.E.; Wash., D.C.

Physician /Medical Examiner

23a. Part1. Enter tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cardiac arrest	
Due to (or as a consequence of): b.	Poor Nutrition	3mos
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.	Alzheimer's Disease	10yrs
Due to (or as a consequence of): d.	Severe Aortic Stenosis	20yrs

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.: Hemorrhagic Gastritis

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes ☒☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of injury *(Month, Day Year)*

28b. Time of injury M

28c. injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MD

29c. Licensa number: D31326

29d. Data signed *(Month, Day, Year)*: 01/05/98

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Richard B. Ashby M.D. 12164 Central Ave, Ste 223, Bowie, MD

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1998

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41377

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Theodore N. Houston
2. Date of Death (Month, Day, Year): December 27, 1997
3. Time of Death: 10:30 P.M.
4a. Facility Name (If not institution, give street and number): 10904 New Salem Avenue
4b. City, Town, or Location of Death: Upper Marlboro
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 579-52-1497
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 82 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 4, 1915
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 10904 New Salem Avenue
10f. Zip Code: 20774
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cabbie
16b. Kind of Business/Industry: Cab Industry (Retired)

17. Father's Name (First, Middle, Last): Eugene N. Houston
18. Mother's Name (First, Middle, Maiden Surname): Ella Chambers

19a. Informant's Name/Relationship (Type, Print): Mrs. Michelle A. Houston Matthews
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10904 New Salem Avenue Upper Marlboro, Maryland 20774

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cemetery
Date: 1/6/98
20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Janet C. Anderson
22. Name and Address of Facility: Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Metastatic prostate cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): [XX] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R.S. Hardy M.D.
29c. License number: D37391
29d. Date signed (Month, Day, Year): 12-31-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Rochelle S. Hardy, M.D. 12172 Central Ave #100 Mitchellville, MD 20721

State Registrar

31. Date filed (Month, Day, Year): JAN 05 1998
32. Registrar's Signature: Judith Mueller Rudolf

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(4)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41378

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Robert William Howard

2. Date of Death Month Day Year: December 29, 1997

3. Time of Death: 11:45 AM

4a. Facility Name *(If not institution, give street and number)*: 5927 Shady Side Road

4b. City, Town, or Location of Death: Shady Side

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 174-22-3798

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 68 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Nov. 14, 1929

9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residance of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Bladensburg

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 5413 Taussig Avenue

10f. Zip Coda: 20710

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Navar Married 2☐ Marriad 3☒ Widowed 4☐ Divorced

12. Was Dacedent Evar in U.S. Armed Forces? 1☒ Yas 2☐ No If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Raca - Amarican Indian, Black, White, atc. *Specify:* White

15. Decedent's Education *(Specify only highast grada compliatad)*: Elamantary/Sacondary (0-12): 12; Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa ratirad)*: Estimator

16b. Kind of Businass/Industry: Printing

17. Fathar's Nama *(First, Middla, Last)*: Robert Morrison Howard

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Clara Wilhelmina Bechtold

19a. Informant's Name/Ralationship *(Type, Print)*: Donald Wayne Howard-Brother

19b. Mailing Address *(Streat and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 5927 Shady Side Road, Shady Side, Maryland 20764

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or othar placa)*: St. John's Lutheran Cemetery

Data: 1-3-98

20c. Location - City or Town, Stata: Pittsburgh, Pennsylvania

21. Signatura of Funaral Sarvica Licansaa: Lisa S. Johnson

22. Nama and Addrass of Facility: Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, Maryland 20722

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one ceuse on aach lina.

Approximata Intarval Batwaen Onset and Death

Immadiata Causa (Final disaasa or condition rasulting in daath)

a. Metastatic Colon Cancer — 5 Years

Dua to (or as a consaquanca of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury thet initiatad avants rasulting in daath) Last

b.

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Othar significant conditions** contributing to death but not resulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the causa of death? 1☐ Yas 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to compliation of causa of daath? 1☐ Yes 2☐ No

25. Was casa rafarrad to medical examinar? 1☐ Yas 2☒ No

26. Placa of Death *(Check only ona)*: Hospital: 1☐ Inpatiant 2☐ ER/Outpatiant 3☐ DOA; Othar: 4☐ Nursing Homa 5☒ Rasidance 8☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding invastigation 6☐ Could not be datarminad

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At home, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledga, death occurrad at the tima, data and placa, and due to tha causa(s) and mannar as stated. 2☐ **Medical Examiner:** On tha basis of axamination and/or invastigation, in my opinion, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar stated.

29b. Signatura and title of cartifiar: [illegible] ATTENDING PHYSICIAN

29c. Licansa number: 34715

29d. Data signad *(Month, Day, Yaar)*: December 30, 1997

30. Nama and addrass of parson who completad cause of daath (Item 23a) (Type, Print): Chira Venkatraman, M.D. 7343A Hanover Parkway, Greenbelt, Maryland 20770

State Registrar

31. Data filed *(Month, Day, Yaar)*: JAN 05 1998

32. Registrar's Signatura: Jackie Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

(10)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 41379

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: HATTIE LEE HARRELL

2. Date of Death Month Day Yaar: DECEMBER 30 1997

3. Tima of Death: 10:35 P.M.

4a. Facility Nema *(If not institution, give street and number)*: MALCOLM GROW MEDICAL CENTER

4b. City, Town, or Location of Death: CAMP SPRINGS

4c. County of Deeth: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 578-64-1611

6. Sax: 1☐ M 2☒ F

7. Aga *(In yrs. last birthday)*: 50 Yrs.

If Under 1 Yaar: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: DECEMBER 30,1947

9. Birthplace *(State or Foreign Country)*: GREENE CTY. N. CAROLINA

Usuel Residence of Decedent

10a. Stata: MARYLAND

10b. County: PRINCE GEORGE'S

10c. City, Town or Location: FORESTVILLE,

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 5507 MARLBORO PIKE APT. #11

10f. Zip Coda: 20747

10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Nevar Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Dacedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No If Yas, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highast grade complatad)*: Elamantery/Secondary (0-12): 10 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: NURSING AIDE

16b. Kind of Businass/Industry: HEALTHCARE

17. Fathar's Nama *(First, Middla, Last)*: HARVEY SWINSON

18. Mothar's Name *(First, Middla, Maiden Sumama)*: ODESSA MITCHELL

19a. Informant's Name/Ralationship *(Type, Print)*: JEROME HARRELL

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 5433 WOODLAND BLVD. OXON HILLS, MD. 20745

20a. Method of Disposition: 1☐ Burial 2☒ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, crematory or othar place)*: METROPOLITAN FUNERAL SERV. Data: 1/5/98

20c. Location - City or Town, Steta: ALEXANDRIA, VIRGINIA

21. Signature of Funeral Sarvica Licensee: Peter Winfield Jones M/D/S

22. Nama end Address of Facility: ALEXANDER S. POPE FUNERAL HOME 5538 MARLBORO PIKE FORESTVILLE, MARYLAND 20747

Physician /Medical Examiner

23a. Part I. Enter tha disease, or complications that caused the daath. Do not enter the mode of dying, such as cardiac or raspiratory errast, shock, or haart failure. List only one cause on aach lina.

Approximata Intarval Between Onset end Death

Immediata Cause (Final diseasa or condition rasulting in death): a. CARDIAC ARRHYTHMIA — 90 MINS

Dua to (or as a consequance of):

Sequantially fist conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Disaasa or injury thet initiated avants rasulting in daath) Last: b. PROBABLE PULMONARY EMBOLUS — UNKNOWN

Due to (or as a consequance of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.: PRIMARY LATERAL SCLEROSIS; HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performad? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was casa refarred to medical examinar? 1☐ Yas 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residance 6☐ Othar *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Sulcide 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

29a. Certifiar *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowladge, daath occurred at tha tima, data and placa, and dua to tha cause(s) and mannar as stated. 2☐ **Medical Examiner**: On tha basis of axamination end/or invastigation, in my opinion, daath occurred at tha tima, data and piece, end dua to tha causa(s) end mannar steted.

29b. Signatura and tita of certifier: Sharon R. O'Brien SHARON R. O'BRIEN, CAPT, USAF, MC 262-11-7556 44M3G PULMONARY / CRITICAL CARE

29c. License number: MD D52353

29d. Date signed *(Month, Day, Year)*: DECEMBER 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHARON R. O'BRIEN, CAPT, USAF, MD 20762

89 MDG 1050 W. PERIMETER ROAD ANDREWS AFB, MD 20762-6600

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 05 1998

32. Registar's Signature: Judi Dunbar-Randall

DHMH 16 Rev 6/95

HATTIE LE HARRELL
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(2)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41380

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ruth Marie Howard
2. Date of Death: Month 12 Day 30 Year 97
3. Time of Death: 3:40 PM
4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 579-42-1885
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 68 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 12-01-29
9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 1703 Monticello Avenue
10f. Zip Code: 20912
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Custodian
16b. Kind of Business/Industry: HealthCare

17. Father's Name (First, Middle, Last): William Gaston
18. Mother's Name (First, Middle, Maiden Surname): Hattie Bates

19a. Informant's Name/Relationship (Type, Print): Richard Howard - SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. BOX 3611; Elm City, North Carolina 27822

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Hamilton Burial Gardens
Date: 01-04-98
20c. Location - City or Town, State: Wilson, N.C.

21. Signature of Funeral Service Licensee: ▶ [signature] #899
22. Name and Address of Facility: Bianchi Funeral Service, 3718 22nd Street NE, Washington, D.C. 20018

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Metastatic adenocarcinoma	one year
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	End Stage Liver disease	
Due to (or as a consequence of):		
c.	Leukopenia	
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature] MD.
29c. License number: D43496
29d. Date signed (Month, Day, Year): 12.30.97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Mohammed A. Khalid M.D. 8830 - Cameron Court Suite 502 Silver Spring MD

State Registrar

31. Date filed (Month, Day, Year): JAN 05 1998
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(4)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41381

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: RANDOLPH IJAMES
2. Date of Death Month Day Year: December 29, 1997
3. Time of Death: 8:56 PM
4a. Facility Name *(If not institution, give street and number)*: Prince George's Hospital
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-36-2385
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 88 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 11-08-1909
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Prince George's
10c. City, Town or Location: Upper Marlboro
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 15411 Peerless Avenue
10f. Zip Code: 20772
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Self-Employed
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Thomas Ijames
18. Mother's Name *(First, Middle, Maiden Surname)*: Katie Wills

19a. Informant's Name/Relationship *(Type, Print)*: Louis Wilson / Son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 15411 Peerless Avenue Upper Marlboro, Maryland 20772

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Moses Cemetery — Date: 01-05-98
20c. Location - City or Town, State: Lothian, Maryland

21. Signature of Funeral Service Licensee: ▶ Nancy A. Pecontic
22. Name and Address of Facility: J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. Pneumonia — 1 week

Due to (or as a consequence of):
b. Impaired Gag Reflex — Many years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c. Cerebrovascular Accident — Many years

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Multiple Cerebral Infarcts, Seizure Disorder, Flexion Contractures

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ MD
29c. License number: D31001
29d. Date signed *(Month, Day, Year)*: January 6, 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Stuart J. Turkewitz, M.D. — 7500 Greenway Center Drive, #430 Greenbelt, Maryland 20770

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1998
32. Registrar's Signature: Gale Anderson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(5)

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41382

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Charles E. Isom
2. Date of Death: Month 12 Day 29 Year 97
3. Time of Death: 10:00A.M.
4a. Facility Name (If not institution, give street and number): 2806 Kingsway Rd.
4b. City, Town, or Location of Death: Fort Washington
4c. County of Death: PG

Funeral Director

5. Social Security Number: 248-42-2908
6. Sex: 1 ☐ M 2 ☐ F — X
7. Age (In yrs. last birthday): 66 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 10-12-31
9. Birthplace (State or Foreign Country): Rockhill S.C.

Usual Residence of Decedent

10a. State: MD. | 10b. County: PG | 10c. City, Town or Location: Fort Washington | 10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 2806 Kingsway Road | 10f. Zip Code: 20744 | 10g. Citizen of What Country? USA

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Clerk-Metro
16b. Kind of Business/Industry: Transportation

17. Father's Name (First, Middle, Last): Paul Isom Sr.
18. Mother's Name (First, Middle, Maiden Surname): Maggie Thompson

19a. Informant's Name/Relationship (Type, Print): Arlene Isom
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2806 Kingsway Rd, Fort Washington Md.20744

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Cheltenham | Date: 1-7-98
20c. Location - City or Town, State: Cheltenham Md.

21. Signature of Funeral Service Licensee: Robert A. Smith
22. Name and Address of Facility: Washington DC 20020 — Robert G. Mason 1661 Good Hope Rd. S.E.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. Adenoid Cystic Carcinoma of left Submandibular salivary gland
Due to (or as a consequence of):
b. Brain Metastasis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Robert M. Applewhaite MD
29c. License number: D21507 MD
29d. Date signed (Month, Day, Year): 1/5/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): OSBERT M. APPLEWHAITE 6196 OXON HILL Rd. #445 OXON HILL, MD 20745

State Registrar

31. Date filed (Month, Day, Year): JAN 05 1998
32. Registrar's Signature: Judi Henderson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

CR

(5)

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 41383

AMENDED # 28a. PER DOCTOR PGC 1-6-98 cr

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Norman Wyatt Jackson, Jr.

2. Data of Death Month / Day / Year: Dec, 27, 1997

3. Time of Death: 13:40

4a. Facility Name *(If not institution, give street and number)*: Prince George Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 223-70-1337

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 48 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: Nov. 17, 1949

9. Birthplace *(State or Foreign Country)*: Wash, DC

Usual Residence of Decadant

10a. State: Maryland

10b. County: Prince George

10c. City, Town or Location: Hyattsville

10d. Insida City Limits: ☒ Yes 2 ☐ No

10e. Street and Number: 5009 54th Street

10f. Zip Coda: 20781

10g. Citizen of What Country?: United States

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forcas? ☒ Yas 2 ☐ No If Yas, Giva Yeer or Datas:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas ☒ No *Specify:*

14. Rece - American Indian, Black, Whita, etc. *Specify:* Black

15. Decedant's Education *(Specify only highest grada complatad)*: Elamantary/Secondary (0-12): 12th; Collega (1-4or 5+):

16a. Decedant's Usual Occupation *(Giva kind of work done during most of working lifa. DO NOT use retired)*: Fork Lift Operator

16b. Kind of Businass/Industry: Retail

17. Fathar's Nama *(First, Middla, Last)*: Norman Wyatt Jackson, Sr.

18. Mothar's Nema *(First, Middla, Maidan Surnema)*: Silvester Norbre Jackson-Richardson

19a. Informant's Name/Raletionship *(Type, Print)*: Nimrod L. Jackson(Brother)

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Steta, Zip Code)*: 5009 54th Ave, Hyattsville, MD 20781

20a. Mathod of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or other place)*: Quantico National Cemetery | Data: 1/5/98

20c. Location - City or Town, Stata: Quantico, Virginia

21. Signeture of Funaral Sarvice Licensaa: Tim McLaney

22. Nama and Addrass of Facility: Latney's Funeral Home, Inc. 3831 Georgia Ave, NW Washington, DC 20011

Physician /Medical Examiner

23a. Part1. Enter the disaasa, of complications that causad tha death. Do not enter tha moda of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only ona ceusa on aach lina.

Approximate Intarval Batwaen Onsat and Death

Immediata Causa (Finel disaasa or condition resulting in daath)

a. Marine gastrointestinal bleeding

Due to (or as a consequanca of):

b. Coagulopathy

Sequantially list conditions, if any, leading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiated evants resulting in daath) Last

Due to (or as a consaquance of):

c. End Stage liver disease

Due to (or as a consequence of):

d. ETHANOL ABUSE

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa given in Part I.: ESOPHAGEAL VARICES

23b. **Did tobacco use contribute to the cause of death?** 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performad? 1 ☐ Yas 2 ☑ No

24b. Were eutopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was casa rafarred to madical exeminer? 1 ☐ Yas 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: ☑ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA | Other: 4 ☐ Nursing Homa 5 ☐ Rasidanca 6 ☐ Othar *(Specify)*

27. Mannar of Death: 1 ☑ Natural 2 ☐ Accidant 3 ☐ Suicide 4 ☐ Homicida 5 ☐ Panding Invastigation 6 ☐ Could not ba datarmined

28a. Data of Injury *(Month, Day Year)*: DEC 27 1997

28b. Tima of Injury: M

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifiar *(Check only one)*: 1 ☑ **Cartifying Phyaician**: To the best of my knowladga, deeth occurred at the time, data end place, and dua to tha causa(s) and mannar as stated. 2 ☐ **Medical Examiner**: On tha basis of examination and/or invastigetion, in my opinion, daath occurred at the time, date and pleca, and due to tha cause(s) and menner stated.

29b. Signature and title of cartifiar: William Boyce

29c. Licansa number: D43662

29d. Data signed *(Month, Day, Year)*: December 31, 1997

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print): William Boyce 3001 Hospital Drive Cheverly, Maryland

State Registrar

31. Data filad *(Month, Day, Year)*: JAN 06 1998

32. Registrar's Signatura: Jackie Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the **Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death.

To the **Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

3

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41384

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ELLA JONES

2. Date of Death (Month, Dey, Year): DECEMBER 27, 1997

3. Time of Death: 07:15 AM

4a. Facility Name (If not institution, give street and number): Prince George's Hospital Center

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 578-05-4055

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 80 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): June 30, 1917

9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Landover

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 1805 Oregon Avenue

10f. Zip Code: 20785

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indian, Black, White, etc. Specify: Black

15. Decedent's Educetion (Specify only highest grade completed)

Elementery/Secondary (0-12): 6th

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Home maker

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): Melvin McMullen

18. Mother's Neme (First, Middle, Meiden Surname): Haily Frederick

19a. Informant's Name/Relationship (Type, Print): Delores Taylor/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1805 Oregon Avenue, Landover, Maryland 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other piece): Harmony Memorial Park

Date: 01/02 1998

20c. Location - City or Town, State: Landover, Maryland

21. Signature of Funerel Service Licensee: ▶ Nancy A. Percentie

22. Name and Address of Facility: J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions that ceused the death. Do not enter the mode of dying, such es cerdiec or respiretory arrest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Fracture right hip

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Respiratory (obstruction lung disease

Due to (or as a consequence of):

c. Circulatory failure.

Due to (or as a consequence of):

d.

APPROVAL PENDING MEDICAL EXAMINER

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en eutopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings available prior to completion of ceuse of deeth? 1☐ Yes 2☐ No

25. Was cese referred to medicel exeminer? 1☒ Yes 2☐ No

26. Place of Death (Check only one)

Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Netural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year): NOV 20, 1997

28b. Time of Injury: 05:00 PM

28c. Injury et Work? 1☐ Yes 2☒ No

28d. Describe how Injury occurred: LEGS BUCKLED AND FELL DOWN ON FLOOR

28e. Place of Injury - At home, farm, streel, factory, office building, etc. (Specify): HOME

28f. Location (Street and Number or Rural Route Number, City or Town, Stete): 1805 OREGON AVENUE, LANDOVER MARYLAND

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶

29c. License number: D 12850

29d. Date signed (Month, Day, Year): December 28, 1997

30. Neme and address of person who completed cause of death (Item 23e) (Type, Print): Bigan Ghovanlou, M.D., 7500 Hanover Parkway, Greenbelt, Maryland 20770

State Registrar

31. Date filed (Month, Dey, Yeer): JAN 05 1998

32. Registrar's Signature: John Henderson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that tha death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for usa as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41385

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: FLARISE JOHNSON
2. Date of Death (Month, Day, Year): DECEMBER 29, 1997
3. Time of Death: 6:AM
4a. Facility Name *(If not institution, give street and number)*: MARINER HEALTH OF SILVER SPRING
4b. City, Town, or Location of Death: SILVER SPRING
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 577-58-1467
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: NOV. 13, 1909
9. Birthplace *(State or Foreign Country)*: NORTH CAROLINA

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2113 WEST VIEW TERR.
10f. Zip Code: 20910
10g. Citizan of What Country?: UNITED STATES AMERICA

11. Marital Status: 1☐ Never Married 2☐ Merried 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 7th GRADE; Collage (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DOMESTIC
16b. Kind of Business/Industry: PRIVATE

17. Father's Name *(First, Middle, Last)*: ROBERT JACKSON
18. Mother's Name *(First, Middle, Maiden Surnama)*: QUEEN STUDEVANT

19a. Informant's Name/Ralationship *(Type, Print)*: MAE N. JONES (DAUGHTER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stata, Zip Code)*: 2113 WEST VIEW TERR., SILVER SPRING, MD. 20910

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Othar *(Specify)*
20b. Placa of Disposition *(Nama of cemetery, crematory or other place)*: HARMONY MEM. CEM.
Date: JAN. 2, 1998
20c. Location - City or Town, State: LANDOVER, MD.

21. Signature of Funeral Servica Licensee:
22. Nama and Address of Facility: JOHNSON & JENKINS INC. 716 KENNEDY ST. N.W., W.D.C. 20011

Physician /Medical Examiner

23a. Part1. Enter the disaase, or complications that causad tha death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failura. List only one cause on each line.

Approximate Intervai Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RESPIRATORY FAILURE — SUDDEN

Dua to (or as a consequance of):
b. SEPSIS — DAYS

Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaasa or injury that initiated evants resulting in death) Last
Dua to (or as a consaquenca of):
c. STROKE — YEARS

Due to (or as a consequence of):
d. ARTRIAL FIBRILLATION

Part II. **Other significant conditions** contributing to daath but not resulting in the underlying cause givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availabla prior to completion of cause of daath? 1☐ Yas 2☐ No

25. Was casa referrad to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Chack only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Mannar of Death: 1☒ Natural 2☐ Accident 3☐ Sulcida 4☐ Homicida 5☐ Pending Investigation 6☐ Could not be datermined

28a. Date of Injury *(Month, Day Yaar)*
28b. Tima of injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Streat and Number or Rural Route Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1☑ **Certifying Physician**: To the best of my knowledga, daath occurred at tha tima, data and placa, and due to the causa(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D-32332
29d. Date signed *(Month, Day, Year)*: JANUARY 1, 1998

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): DR. SURESH GUPTA, M.D. 9801 GEORGIA AVE. APT. 220, SILVER SPRING, MD. 20902

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 05 1998
32. Registrar's Signature:

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41386

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOSEPH JONES

2. Date of Death Month: 12 Day: 26 Year: 97

3. Time of Death: 640 AM

4e. Facility Name (If not institution, give street and number): GENESIS AT LAYHILL

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 016-07-3684

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 11, 1911

9. Birthplace (State or Foreign Country): N.C.

Usual Residence of Decedent

10a. State: MD

10b. County: Montgomery

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: ☒1 Yes 2☐ No

10e. Street and Number: 3227 Bel Pre Road

10f. Zip Code: 20906

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12th.

College (1-4or 5+):

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

16b. Kind of Business/Industry: Spaulding and Evenflo Co.

17. Father's Name (First, Middle, Last): Alonzo Jones

18. Mother's Name (First, Middle, Maiden Surname): Mary A. Alexander

19a. Informant's Name/Relationship (Type, Print): Ethel L. LAtta

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14744 Silver Stone Dr. Silver Spring, Md. 20905

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan

Date: 12-29-97

20c. Location - City or Town, State: Arlington, Va.

21. Signature of Funeral Service Licensee: Julia B Marshall

22. Name and Address of Facility: Marshall's Funeral Home 4217 9th. St. N.W. Wash. D.C. 20011

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. ATHEROSCLEROTIC HEART DISEASE — 10 YEARS

Due to (or as a consequence of):

b. HYPERTENSION — 10 YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMER'S DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one)

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Francisco A. Mathews MD

29c. License number: D41460

29d. Date signed (Month, Day, Year): 12/29/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): FRANCISCO A. MATHEWS MD. 13018 Georgia Ave. Wheaton, Md. 20906

State Registrar

31. Date filed (Month, Day, Year): JAN 05 1998

32. Registrar's Signature: Joyce Dutcher Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #s 20b & 20c, PG, GC, 1/13/98

Certificate of Death

Reg. No. 97 41387

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Silas J. Jackson

2. Date of Death (Month, Day, Year): December 28, 1997

3. Time of Death: 10:47 A

4a. Facility Name (If not institution, give street and number): 11235 Oak Leaf Drive #709

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery County

Funeral Director

5. Social Security Number: 242-18-8237

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): August 5, 1923

9. Birthplace (State or Foreign Country): Lenoir, North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery County

10c. City, Town or Location: Silver Spring

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 11235 OakLeaf Drive #709

10f. Zip Code: 20901

10g. Citizen of What Country? United States of America

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Chemist

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): John Thomas Jackson

18. Mother's Name (First, Middle, Maiden Surname): Nancy Randall

19a. Informant's Name/Relationship (Type, Print): Evelyn Queen/ Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1727 Kalmia Road, N.W., Washington, D.C. 20012

20a. Method of Disposition: 1 [✓] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): ~~unk~~ Arlington National Cem. Date: 1/19/98

20c. Location - City or Town, State: ~~unk~~ Arlington Va.

21. Signature of Funeral Service Licensee: Juan Smith

22. Name and Address of Facility: John T. Rhines and Company Funeral Home, 3030 12th Street, N.E., Washington, DC

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION — ACUTE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [✓] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [✓] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [✓] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [✓] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Francis C. Mayle

29c. License number: D07099

29d. Date signed (Month, Day, Year): DEC 30 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS C MAYLE 10215 FERNWOOD RD BETHESDA MD 20817

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by this funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

5

State Registrar

31. Date filed (Month, Day, Year): JAN 09 1998

32. Registrar's Signature: Jacqueline Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41388

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Bertha Mae Kelly

2. Date of Death — Month: December Day: 21 Year: 1997

3. Time of Death: 9:30 P.M.

4a. Facility Name *(If not institution, give street and number)*: Evergreen Rehabilitation & Nursing Center

4b. City, Town, or Location of Death: Baltimore (City)

4c. County of Death:

Funeral Director

5. Social Security Number: 122-28-2999

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 94 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 7, 1903

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2525 W. Belvedere Avenue

10f. Zip Code: 21214

10g. Citizen of What Country?: United States of America

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): 8 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: Albert Louis Dawson

18. Mother's Name *(First, Middle, Maiden Surname)*: Ponoperao Brothers

19a. Informant's Name/Relationship *(Type, Print)*: Eulah Barnard

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 81 David Whites Lane, Southampton, NY11968

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Southampton Cemetery

Date: December 26, 1997

20c. Location - City or Town, State: Southampton, New York

21. Signature of Funeral Service Licensee #M00690: Howard A Causey

22. Name and Address of Facility: Brockett Funeral Home, Inc. 203 Hampton Road, Southampton, NY 11968

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular disease — 4yrs

Due to (or as a consequence of):

b. Cerebrovascular accident — 4years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Multiple Decubiti — 1 yr.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Renal Insufficiency

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☒ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)* — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)* — 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Amatun N. Naeem MD

29c. License number: D15503

29d. Date signed *(Month, Day, Year)*: December 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): AMATUN N NAEEM, 501 Dolphin street Baltimore MD 21217

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 08 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41389

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: IDA M. MEADOWS

2. Dete of Deeth — Month: December — Dey: 30 — Yeer: 1997

3. Time of Deeth: 1:30 a.m.

4e. Feclity Name *(If not institution, giva street and number)*: Harbor Hospital Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Deeth: N/A

Funeral Director

5. Social Security Number: 218-24-6084

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 83 Yrs.

If Under 1 Year — Months: | Deys: | If Under 24 Hrs. — Hours: | Min.:

8. Dete of Birth *(Month, Day, Year)*: MAR. 23, 1914

9. Birthplece *(State or Foreign Country)*: MARYLAND

Usuel Residence of Decedent

10e. Stete: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: LINTHICUM

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6862 BALTIMORE & ANNAPOLIS BLVD.

10f. Zip Code: 21090

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Nevar Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forcas? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxicen, Puarto Ricen, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - Amaricen Indien, Black, White, etc. *Specify:* WHITE

15. Decadent's Education *(Specify only highast grade completed)*: Elementary/Secondery (0-12): 8 | College (1-4or 5+): N/A

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: DIETARY

16b. Kind of Business/Industry: CROWNSVILLE STATE HOSP.

17. Fether's Neme *(First, Middle, Last)*: CHARLES NOSH

18. Mother's Neme *(First, Middle, Maiden Surname)*: ELVA CLARE

19e. Informent's Neme/Relationship *(Type, Print)*: DONNA D. MEADOWS (PERSONAL REPRESENATIVE)

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: 6862 BALTIMORE & ANNAPOLIS BLVD., LINTHICUM, MD. 21090

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stata 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Name of cemetery, crematory or other piece)*: GLEN HAVEN MEMORIAL PARK — Dete: 1/2/98

20c. Location - City or Town, Stete: GLEN BURNIE, MD.

21. Signature of Funeral Service Licensee

22. Nama and Address of Facility: SINGLETON FUNERAL HOME, 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications thet caused the deeth. Do not enter tha mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Finel diseese or condition resulting in deeth): e. Fatal Cardiac Arrhythmia — 34 MINUTES

Due to (or es e consequence of):

Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Lest:

b. Coronary Artery Disease — UNKNOWN

Due to (or es e consequence of):

c. HYPERTENSION — UNKNOWN

Due to (or as a consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure

Congestive Heart Failure

23b. Did tobacco use contribute to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24e. Wes en eutopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings evalleble prior to completion of causa of deeth? 1☐ Yes 2☒ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Pending investigetion 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury

28c. Injury et Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, ferm, street, factory, office building, etc. *(Spacify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exeminetion end/or invastigetion, in my opinion, death occurred at the time, dete end place, and due to the ceuse(s) end menner stated.

29b. Signature and title of certifier: Satinder Gill, M.D. PGY-1

29c. Licansa number: AHS 2441614-A4

29d. Data signed *(Month, Day, Year)*: December 30, 1997

30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Satinder Gill Harbor Hospital Center 1300 S. Hanover St. Baltimore, MD 21225

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 06 1998

32. Registrer's Signetura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41390

Certificate of Death

Reg. No.

MALECKI DOROTHEA

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DOROTHEA MARGARETTE MALECKI
2. Date of Death Month / Day / Year: December 31, 1997
3. Time of Death: 8:24 PM
4a. Facility Name *(If not institution, give street end number)*: NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Death: GLEN BURNIE
4c. County of Death: A.A. COUNTY

Funeral Director

5. Social Security Number: 213-22-1909
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 84 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: JAN. 11, 1913
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: SEVERN
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8714 CREST ROAD
10f. Zip Code: 21144
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SUPERVISOR
16b. Kind of Business/Industry: ANNE ARUNDEL / MARYLAND STATE

17. Father's Name *(First, Middle, Last)*: PAUL R. SCHULTZ
18. Mother's Name *(First, Middle, Maiden Surname)*: FREDERICKA K. RACE

19a. Informant's Name/Relationship *(Type, Print)*: KATHERINE D. MALECKI (DAUGHTER)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8714 CREST ROAD, SEVERN, MARYLAND 21144

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: GLEN HAVEN MEMORIAL PARK | Date: 1/3/98
20c. Location - City or Town, State: GLEN BURNIE, MD

21. Signature of Funeral Service Licensee: Donald L Kaack
22. Name and Address of Facility: SINGLETON FUNERAL HOME 1 SECOND AVE. S.W., GLEN BURNIE, MARYLAND 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Pancreatic cancer — Unos

Due to (or as a consequence of):
b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D50108
29d. Date signed *(Month, Day, Year)*: 1/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael Downing, MD 7845 Oakwood Rd. Suite 201, Glen Burnie, MD 21061

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41391

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Abdul Majid
2. Date of Death (Month, Day, Year): December 26, 1997
3. Time of Death: 9:30 AM
4a. Facility Name (If not institution, give street and number): Cromwel-Genesis-Eldercare
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 448-58-9755
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): July 15, 1917
9. Birthplace (State or Foreign Country): Agra, India

Usual Residence of Decedent

10a. State: Oklahoma
10b. County: Oklahoma
10c. City, Town or Location: Edmond
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 5000 Summit Drive
10f. Zip Code: 73034
10g. Citizen of What Country?: United States of America

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Rece - American Indian, Black, White, etc. Specify: Asian

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12): | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Hospital Administration
16b. Kind of Business/Industry: Health Care

17. Father's Name (First, Middle, Last): Abdul Majid
18. Mother's Name (First, Middle, Meiden Surneme): (Unavailable)

19a. Informant's Name/Relationship (Type, Print): Khan Khela Majid - Wife
19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 5000 Summit Drive Edmond, OK 73034

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremefory or other piece): Memorial Park Cemetery
Date: 1-2-98
20c. Location - City or Town, State: Oklahoma City, OK

21. Signature of Funeral Service Licensee: Karen W. Rose
22. Name end Address of Facility: Beggarly Funeral Home 930 S. Broadway Edmond, Oklahoma 73034

Physician /Medical Examiner

23a. Part I. Enter the disease, or complicetions that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final diseese or condition resulting in death): a. Cerebrovascular Accident
Due to (or es a consequence of): b. Dementia
Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c. Sepsis.
Due to (or as e consequence of): d.

Part II. **Other significant conditiona** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the causa of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residenca 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the besis of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end place, end due to the ceuse(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D41901
29d. Dete signed (Month, Dey, Year): 12/26/97

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print): 3007 E Northern Parkway, Baltimore, MD 21214

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41392

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ROBERT MAURICE McCRAY

2. Date of Death: Month: December; Day: 29; Year: 1997

3. Time of Death: 5:32 PM

4a. Facility Name (If not institution, give street and number): Maryland General Hospital

4b. City, Town, or Location of Death: Baltimore City

4c. County of Death:

Funeral Director

5. Social Security Number: 578-54-6722

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 57 Yrs.

If Under 1 Year: Months: ; Days:

If Under 24 Hrs.: Hours: ; Min.:

8. Date of Birth (Month, Day, Year): Dec. 8 1942

9. Birthplace (State or Foreign Country): Wash., DC

Usual Residence of Decedent

10a. State: --

10b. County: --

10c. City, Town or Location: Washington, D.C.

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street end Number: 277 V St., N.W.

10f. Zip Code: 20001

10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Datas:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - Americen Indian, Bleck, Whita, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementery/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Auto Detailing

16b. Kind of Business/Industry: Detailing

17. Father's Nema (First, Middle, Last): Lester McCray

18. Mother's Neme (First, Middle, Maiden Surneme): Lula Henderson

19e. Informent's Name/Relationship (Type, Print): Delores Belzer Sister

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 277 V St., N.W. Wash., DC 20001

20a. Method of Disposition: 1 [X] Buriel 2 [ ] Cramation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other place): Glenwood Cemetery

Date: 1-6-98

20c. Location - City or Town, State: Washington, D.C.

21. Signature of Funeral Service Licensee: Sharon Johnson-Talley

22. Name end Address of Facility: Capitol Mortuary 1425 Maryland Ave., NE Wash., DC 20002

To Be Completed by Funeral Director

Robert McCray

CR

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the disease or complications thet ceused the death. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one ceuse on each line.

Approximete Intervel Between Onset and Death

Immediate Ceuse (Final diseese or condition resulting in death)

a. Aspiration pneumenia

Due to (or es e consequenca of):

Sequentially list conditions, if any, leading to Immadiata cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest

b. Sepsis

Due to (or es e consequenca of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No

24b. Were eutopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [ ] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29e. Certifier (Check only one): 1 [X] Certtfying Phyaicten: To the best of my knowledge, death occurred et the time, dete and piece, and due to the ceuse(s) and menner as stated. 2 [ ] Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the ceuse(s) and manner stated.

29b. Signeture end title of certifier: Sajjad Azziz, M.D.

29c. License number: 89288

29d. Date signed (Month, Day, Year): December 29, 1997

30. Name end address of person who completed causa of death (Item 23e) (Type, Print): Sajjad Azziz, M.D. c/o Maryland General Hospital

State Registrar

31. Dete filed (Month, Dey, Year): JAN 07 1998

32. Registrar's Signature: John Dutcher-Perdue

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41393

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Albert Miller
2. Date of Death (Month, Dey, Yeer): December 28, 1997
3. Time of Death: unk.
4a. Facility Neme (If not institution, give street end number): 4411 39th St
4b. City, Town, or Location of Deeth: Brentwood
4c. County of Deeth: Prince Georges

Funeral Director

5. Sociel Security Number: 577-60-9955
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthdey): 49 Yrs.
If Under 1 Year: Months / Deys
If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): Mar 5, 1948
9. Birthplece (State or Foreign Country): Washington

Usuel Residence of Decedent

10e. Stete: Md
10b. County: Prince Georges
10c. City, Town or Location: Brentwood
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 4411 39th St
10f. Zip Code: 20722
10g. Citizen of What Country: USA
11. Meritel Stetus: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? ☒Yes 2☐No If Yes, Give Yeer or Dates: 68-70
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐Yes 2☒No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): / College (1-4or 5+): 4
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Federal Police
16b. Kind of Business/Industry: Law Enforcement
17. Fether's Neme (First, Middle, Last): Will Miller
16. Mother's Neme (First, Middle, Meiden Surneme): Mattie Williams
19e. Informent's Neme/Reletionship (Type, Print): Mary L. Miller/ Wife
19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 4411 39th St Brentwood Md 20722
20e. Method of Disposition: 1☒Buriel 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other piece): Arlington Cemetery
Dete: 1/7/98
20c. Location - City or Town, State: Arlington Va
21. Signeture of Funerel Service Licensee: Roger J Mann
22. Neme end Address of Feciliity: Sterling Funeral Service 1601 Kenilworth Ave NE Wash DC 20019

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heert failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in deeth)
e. CONGESTIVE HEART FAILURE

Due to (or es e consequence of):
b. ARTERIOSCLEROTIC HEART DISEASE

Sequentielly list conditions, if eny, teeding to immediete cause. Enter Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Last

Due to (or es e consequence of):
c. DIABETES MELLITUS

Due to (or es e consequence of):
d.

Pert II. **Other significent conditions** contributing to deeth but not resulting in the underlying ceuse given in Pert I.

23b. Did tobecco use contribute to the ceuse of deeth? 1☐Yes 2☒No 3☐Probebly 4☐Unknown

24a. Wes en autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings evailable prior to completion of ceuse of deeth? 1☐Yes 2☒No

25. Wes cese referred to medicel exeminer? 1☐Yes 2☒No

26. Piece of Deeth (Check only one): Hospitel: 1☐Inpetient 2☐ER/Outpetient 3☐DOA Other: 4☐Nursing Home 5☒Residence 6☐Other (Specify)

27. Manner of Deeth: 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28a. Dete of Injury (Month, Dey Yeer):
28b. Time of Injury: M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred:
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify):
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete):

29a. Certifier (Check only one): 1☒**Certifying Physicien:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner as stated. 2☐**Medicel Exeminer:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier:
29c. License number: D07915
29d. Dete signed (Month, Dey, Yeer): JANUARY 6, 1998

30. Neme end eddress of person who completed ceuse of deeth (Item 23e) (Type, Print): IBRAHIM KHATRI, M.D. VAMC 50 IRVING STREET, N.W. WASHINGTON, DC 20422

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 07 1998
32. Registrar's Signeture: Julia Davidson Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41394

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MAMIE MOORE

2. Date of Death (Month, Dey, Year): DECEMBER 31 1997

3. Time of Death: 2:35 PM

4a. Facility Name (If not institution, give street and number): DOCTOR'S HOSPITAL

4b. City, Town, or Location of Death: LANHAM, MD

4c. County of Death: PRINCES GEORGES

Funeral Director

5. Social Security Number: 137-14-6830

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 97 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Dey, Year): 9-28-1900

9. Birthplace (State or Foreign Country): PLEASANTVILLE NEW JERSEY

Usual Residence of Decedent

10a. State: MD

10b. County: PRINCE GEORGES

10c. City, Town or Location: SPRINGDALE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 3510 ST. JOHN PLACE

10f. Zip Code: 20774

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decadent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 6TH

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): KITCHEN WORKER

16b. Kind of Business/Industry: DENIS HOTEL

17. Father's Name (First, Middle, Last): JAMES CAMPBELL

18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): JONAS MOORE - SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3510 ST. JOHN PLACE, SPRINGDALE MD 20774

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): PLEASANTVILLE, CEM.

Date: 1-9 1998

20c. Location - City or Town, State: PLEASANTVILLE N.J.

21. Signature of Funeral Service Licensee: B.C. Taylor

22. Name and Address of Facility: TAYLOR'S FUNERAL HOME 1722 NORTH CAPITOL ST NW WASH., DC

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATELECTASIS OF LUNG — 2 3-4 hours

Due to (or as a consequence of):

b. UROSEPSIS — 3 days.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. PNEUMONIA — 3 days

Due to (or as a consequence of):

d. ASPIRATION PNEUMONIA — 10-15 minutes

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ARTHRITIS

HISTORY OF PD - CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Samuel Alleyne

29c. License number: D25766

29d. Date signed (Month, Day, Year): 1/3/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. SAMUEL ALLEYNE P.O.BOX 659 COLLEGE PARK, MD 20741

State Registrar

31. Date filed (Month, Day, Year): JAN 05 1998

32. Registrar's Signature: Julie Mahoney Parker

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

MAMIE MOORE

(5)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41395

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Ann Myles-Whitaker
2. Date of Death Month: DECEMBER 31 Day Year: 1997
3. Time of Death: 11:46 AM
4a. Facility Name *(If not institution, give street and number)*: Doctor's Hospital
4b. City, Town, or Location of Death: Lanham
4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 204-50-6058
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 38 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 02-14-59
9. Birthplace *(State or Foreign Country)*: Pennsylvania

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George's
10c. City, Town or Location: Glendale
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6508 Facchina Lane
10f. Zip Code: 20769
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4 or 5+): 4+
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Realtor/Singer
16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Carl E. Myles Sr.
18. Mother's Name *(First, Middle, Maiden Surname)*: Jane Ann Harris

19a. Informant's Name/Relationship *(Type, Print)*: Henry Whitaker/Husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6508 Facchina Lane, Glendale, Maryland 20769

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Ft. Lincoln Cemetery — Date: 1/10/98
20c. Location - City or Town, State: Brentwood, MD

21. Signature of Funeral Service Licensee: Charles F Bowman
22. Name and Address of Facility: J. B. Jenkins Funeral Home, 7474 Landover Road, Landover, Maryland 20785

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Ac Arrythmia — 1mnth

Due to (or as a consequence of):
b. Met. Breast Cancer — 4yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: N/A
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: N/A
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Jeffrey J. Hong MD
29c. License number: D33983
29d. Date signed *(Month, Day, Year)*: 12/31/97

30. Name and address of person who completed cause of death (Item 23) (Type, Print): Jeffrey J. Hong, M.D. 7695 Sweet Hours Way, Columbia, Maryland 21046

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998
32. Registrar's Signature: Judith Mueller Randall

DHMH 16 Rev 6/95

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

MARY ANN MYLES-WHITAKER

ck

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41396

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Philip James Procaccino

2. Deta of Deeth — Month: December Day: 24 Year: 1997

3. Tima of Death: 1050A

4e. Facility Nama (If not institution, give street and number): Johns Hopkins

4b. City, Town, or Location of Deeth: Baltimore

4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 155-42-6647

6. Sax: 1☒M 2☐F

7. Aga (In yrs. last birthday): 33 Yrs.

If Under 1 Year — Months: Days:

If Under 24 Hrs. — Hours: Min.:

8. Dete of Birth (Month, Day, Year): Mar. 27, 1964

9. Birthplace (Stata or Foraign Country): Vineland, NJ

Usual Residence of Decedant

10a. State: Pennsylvania

10b. County: Bucks

10c. City, Town or Location: Newtown

10d. Inside City Limits: 1☒Yas 2☐No

10e. Street and Number: 2092 Farmview Drive

10f. Zip Coda: 18940

10g. Citizen of What Country? United States of America

11. Maritel Stetus: 1☐Nevar Merried 2☒Merried 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forcas? 1☐Yas 2☒No If Yas, Give Yaer or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐Yes 2☒No Specify:

14. Race - Amarican Indian, Black, White, etc. Specify: White

15. Decedant's Education (Specify only highest grada complated)

Elementary/Secondary (0-12):

Collaga (1-4or 5+): 4

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired): Financial Systems Manager

16b. Kind of Businass/Industry: Finance

17. Fathar's Name (First, Middla, Last): Patrick Procaccino

18. Mothar's Nama (First, Middle, Maiden Sumama): Patricia Nutt

19a. Informant's Name/Reletionship (Type, Print): Patricia Procaccino/ Mother

19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, Stata, Zip Code): 719 Dukes Road, Vineland, New Jersey 08360

20a. Mathod of Disposition: 1☒Burial 2☐Cramation 3☐Ramoval from Stata 4☐Donetion 5☐Othar (Spacify)

20b. Plece of Disposition (Name of cematary, cramatory or othar place): Sacred Heart Cemetery

Data: Dec 29, 1997

20c. Location - City or Town, Stata: Vineland, New Jersey

21. Signatera of Funeral Service Licansee: #M00690 Howard A Causen

22. Nama and Addrass of Facility: Rone Funeral Service, 1110 East Chestnut Ave., Vineland, NJ 08360

Physician /Medical Examiner

23a. Part1. Enter tha disaese, or complicatlons that caused tha daath. Do not entar the moda of dying, such es cardiec or respiretory errast, shock, or haart feilure. List only one ceusa on aach lina.

Approximata Intarval Between Onset and Deeth

Immediate Ceuse (Final disease or condition resulting in daath)

e. Diffuse Alveolar Damage — 1week

Dua to (or as a consequanca of):

Sequentially list conditions, if any, leeding to immadiate causa. Entar Underlying Causa (Disaasa or injury that initiated events rasulting in deeth) Last

b.

Due to (or es a consequance of):

c.

Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to daath but not resulting in tha undarlying causa given in Part I.

Post Bone Marrow Transplant For Non Hodgkins Lymphoma

23b. Did tobacco usa contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Wara autopsy findings aveileble prior to compiation of causa of death? 1☐Yas 2☒No

25. Wes casa rafarrad to medical examinar? 1☐Yas 2☒No

26. Placa of Daath (Check only ona) — Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Homa 5☐Residance 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicida 4☐Homicida 5☐Panding Investigation 6☐Could not be determined

28a. Deta of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Dascribe how injury occurred

28e. Plece of Injury - At home, farm, straat, factory, office building, atc. (Specify)

28f. Location (Straat and Number or Rural Route Number, City or Town, Stete)

29a. Cartifier (Check only one): 1☒**Cartifying Phyaician:** To tha best of my knowledge, deeth occurrad at tha tima, dete end plece, end dua to tha causa(s) and mannar as stated. 2☐**Medical Examiner:** On tha basis of axeminetion and/or investigation, in my opinion, death occurred at the time, date end plece, end due to tha causa(s) end manner steted.

29b. Signeture end titla of certifiar: Julie R Brahmer, MD

29c. Licansa number: D0051770

29d. Data signed (Month, Day, Year): December 24 1997

30. Nama and addrass of person who completed cause of daath (Item 23a) (Type, Print): Julie R. Brahmer, M.D. Johns Hopkins, Baltimore MD.

State Registrar

31. Data filad (Month, Day, Year): JAN 02 1998

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rav 6/95

Baltimore, Maryland 21215-0020

permit. Pagas 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after deeth.
To the Funeral Director: Aftar this certificata has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41397

Reg. No.

Physician /Medical Examiner

1. Decadant's Nama *(First, Middla, Last)*: Richard Owen Paddy

2. Data of Death Month / Day / Yaar: December 30 1997

3. Tima of Death: 8:35PM

4a. Facility Nama *(If not institution, giva street and number)*: 6016 Allwine Ave. Deale, MD

4b. City, Town, or Location of Death: Deale

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 215-90-4750

6. Sex: 1☒M 2☐F

7. Aga *(In yrs. last birthday)*: 33 Yrs.

If Undar 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Yaar)*: July 12, 1964

9. Birthplace *(Stata or Foraign Country)*: Maryland

Usual Residance of Dacadant

10a. Stata: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Deale

10d. Insida City Limits: 1☐Yas 2☒No

10e. Straat and Numbar: 6016 Allwine Avenue

10f. Zip Coda: 20751

10g. Citizan of What Country?: United States

11. Marital Status: 1☒Navar Marriad 2☐Marriad 3☐Widowad 4☐Divorcad

12. Was Dacadant Evar in U.S. Armad Forcas? 1☐Yas 2☒No If Yas, Giva Yaar or Datas:

13. Was Dacadant of Hispanic Origin? (Spacify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.): 1☐Yas 2☒No *Spacify:*

14. Race - American Indian, Black, Whita, atc. *Specify:* White

15. Decadant's Education *(Spacify only highast grada complatad)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decadant's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retirad)*: self employed

16b. Kind of Businass/Industry: Paddy Tree Service

17. Fathar's Nama *(First, Middla, Last)*: Owen A. Paddy

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Martha Laster

19a. Informant's Name/Relationship *(Type, Print)*: Martha Paddy (mother)

19b. Mailing Address *(Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 1630 Millstone Dr. P.O. Box144 Edgewater, MD 21037

20a. Mathod of Disposition: 1☐Burial 2☒Cramation 3☐Ramoval from Stata 4☐Donation 5☐Othar *(Specify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: Fort Lincoln Crematory

Data: Jan.01,1998

20c. Location - City or Town, Stata: Brentwood, MD

21. Signature of Funaral Service Licensee: [signature]

22. Nama and Addrass of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximate Interval Between Onset and Death

Immediata Causa (Final disaasa or condition resulting in daath)

a. GASTRIC CANCER — 20 MTHS

Due to (or as a consequance of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Causa (Disaasa or injury that initiatad avants resulting in daath) Last

b. — Dua to (or as a consequance of):

c. — Dua to (or as a consaquance of):

d.

Part II. **Other significant conditions** contributing to daath but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yas 2☒No

24b. Were autopsy findings available prior to completion of causa of daath? 1☐Yas 2☒No

25. Was case rafarrad to medical examinar? 1☐Yas 2☒No

26. Placa of Death *(Check only ona)*: Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA Other: 4☐Nursing Homa 5☒Rasidance 6☐Othar *(Specify)*

27. Mannar of Death: 1☒Naturel 2☐Accidant 3☐Suicida 4☐Homicida 5☐Panding Invastigation 6☐Could not be datarmined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury M

28c. Injury at Work? 1☐Yas 2☐No

28d. Dascriba how injury occurrad

28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Routa Number, City or Town, Stata)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Cartifiar *(Check only one)*: 1☒**Certifying Physician**: To tha best of my knowledga, daath occurrad at tha tima, data and placa, and dua to the causa(s) and mannar as stated. 2☐**Medical Examiner**: On tha basis of axamination and/or investigation, in my opinion, daath occurrad at tha time, data and placa, and dua to the causa(s) and mannar stated.

29b. Signatura and title of cartifiar: [signature]

29c. Licansa number: D16354

29d. Data signad *(Month, Day, Yaar)*: 12/31/97

30. Nama and addrass of parson who completad causa of daath (Item 23a) (Type, Print): EW COLE 900 BESTGATE RD ANNAPOLIS MD

State Registrar

31. Data filad *(Month, Day, Yaar)*: JAN 06 1998

32. Registrar's Signatura: [signature]

DHMH 16 Rev 6/95

4 242 -0300

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41398

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Beatrice Patterson

2. Date of Death Month / Day / Year: DEC. 25 97

3. Time of Death: 3:15 p.m.

4a. Facility Name *(If not institution, give street and number)*: LIVINGSTON HEALTH CARE CENTER

4b. City, Town, or Location of Death: FT. WASH.

4c. County of Death: P.G.

Funeral Director

5. Social Security Number: 577 30 5000

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 91 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: OCT. 15, 1906

9. Birthplace *(State or Foreign Country)*: WASH DC

Usual Residence of Decedent

10a. State: md.

10b. County: P.G.

10c. City, Town or Location: FT. WASHINGTON

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 12021 LIVINGSTON RD.

10f. Zip Code: 20744

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK.

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8TH. | College (1-4or 5+): —

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: DOMESTIC

16b. Kind of Business/Industry: HOUSEKEEPING

17. Father's Name *(First, Middle, Last)*: UNKNOWN

18. Mother's Name *(First, Middle, Maiden Surname)*: UNKNOWN

19a. Informant's Name/Relationship *(Type, Print)*: LAURA HARRIS

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2404 KINGS WAY RD. FT. WASH MD 20744

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ARLINGTON NAT. | Date: 1-7-98

20c. Location - City or Town, State: ARLINGTON, VA.

21. Signature of Funeral Service Licensee: Juan Smith

22. Name and Address of Facility: JOHN T. RHINES 3030 - 12TH. ST. N.E. WASH DC 20017

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Carcinoma of Pancreas — 12/5/97 / 12/25/97

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Diabetis Mellitus.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* | 28b. Time of Injury | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* | 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D24064

29d. Date signed *(Month, Day, Year)*: 12/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): SHANTHA MURPHY, MD, 6196 OXON HILL ROAD, OXON HILL, MD 20745 SUITE# 240

4

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1998

32. Registrar's Signature: Julie Strudwick-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41399

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ESSIE L PUGH
2. Date of Death (Month, Day, Year): December 30, 1997
3. Time of Death: 8:35 A.m.
4a. Facility Name (If not Institution, give street and number): SOUTHERN MARYLAND HOSPITAL
4b. City, Town, or Location of Death: CLINTON
4c. County of Death: PRINCE George's

Funeral Director

5. Social Security Number: 238-48-8436
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs. | If Under 1 Yaar: Months / Deys | If Undar 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Year): Dec. 11 1933
9. Birthpiece (State or Foraign Country): N.C. Edenton, USA

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Prince Geo.
10c. City, Town or Location: Temple Hills
10d. Inside City Limits: 1☒ Yas 2☐ No
10e. Street end Number: 3520 Chadwick Court
10f. Zip Code: 20748
10g. Citizen of Whet Country? USA

11. Marital Status: 1☐ Never Married 2☒ Merried 3☐ Widowed 4☐ Divorcad
12. Was Decedent Ever in U.S. Armad Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 4 | College (1-4or 5+):
16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired): Child Care Provider
16b. Kind of Business/Industry: Self-Employed

17. Fether's Neme (First, Middle, Last): Eli Mayo
18. Mother's Neme (First, Middle, Meiden Surneme): Eliza Lamb

19a. Informent's Neme/Relationship (Type, Print): Edward E. Pugh
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 3520 Chadwick Ct., Temple Hills, MD 20748

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donetion 5☐ Other (Specify)
20b. Piece of Disposition (Neme of camatery, cremetory or other piece): Resurrection Cemetary
Date: 1-3-98
20c. Location - City or Town, Stete: Clinton, MD

21. Signature of Funeral Service Licensee: [signature]
22. Neme end Address of Feciility: Strickland Funeral Services, 6500 Allentown Rd., Camp Spgs., MD 20748

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximete Intervel Between Onset and Deeth

Immediete Ceuse (Finel diseese or condition resulting in deeth):
e. Septicemia — New

Due to (or es e consequence of):
b. gangrene Right foot — New

Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
Due to (or es e consequence of):
c. END Staph aureus Sepsis — May/Jun

Due to (or es a consequence of):
d. insulin dependent Diabetes mellitus — May/Jun

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings eveilable prior to completion of causa of deeth? 1☐ Yes 2☐ No

25. Wes case refarred to medical examiner? 1☐ Yas 2☑ No

26. Piece of Deeth (Check only one): Hospitel: 1☑ Inpatient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth: 1☑ Neturei 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of injury (Month, Dey Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Piece of injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Phyeician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, dete and pieca, and due to the ceuse(s) end manner stated.

29b. Signeture and title of certifier: K. Davachi MD
29c. License number: D25640
29d. Date signed (Month, Dey, Year): 12-31-97

30. Neme end address of person who completed cause of deeth (Item 23e) (Type, Print): Khosrow Davachi 7503 Surratts Rd. Clinton Md. 20735

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 05 1998
32. Registrer's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

CR

10

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AMEND: #17 1/8/98 mcg AACO Health Dept.
AMEND# 16B 1-6-98 cms AACO HEALTH DEPT

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41400
Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): JAMES S. ROGERS
2. Dete of Deeth — Month: DEC Day: 30 Yeer: 97
3. Time of Deeth: 2:43PM
4e. Facility Neme (If not institution, give street end number): NORTH ARUNDEL HOSPITAL
4b. City, Town, or Location of Deeth: GLEN BURNIE
4c. County of Deeth: AA

Funeral Director

5. Social Security Number: 225-20-8624
6. Sex: 1☒M 2☐F
7. Age (In yrs. lest birthday): 73 Yrs. — If Under 1 Year: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): Sept 9, 1924
9. Birthplece (Stete or Foreign Country): Virginia

Usuel Residence of Decedent

10a. Stete: MD
10b. County: Anne Arundel
10c. City, Town or Location: Millersville
10d. Inside City Limits: 1☐Yes 2☒No
10e. Street end Number: 827 Cedarcroft Drive
10f. Zip Code: 21108
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1☐Yes 2☒No Specify:
14. Rece - American Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grede completed): Elementery/Secondery (0-12): — College (1-4or 5+): 4
16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Engineer
16b. Kind of Business/Industry: ~~National Security Agency~~ NASA

17. Fether's Neme (First, Middle, Lest): Frederick ~~Ray~~ Rogers
18. Mother's Neme (First, Middle, Meiden Surneme): Dorothy Neal

19a. Informent's Neme/Reletionship (Type, Print): Gladys Rogers/wife
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 827 Cedarcroft Drive, Millersville, MD 21108

20a. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from State 4☐Donetion 5☐Other (Specify)
20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Baldwin Memorial Church Cemetery
Dete: Jan 2 1998
20c. Location - City or Town, State: Millersville, MD

21. Signature of Funeral Service Licensee: Robert B. Barranco
22. Neme and Address of Feciility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complications thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Interval Between Onset and Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth): e. LUNG CANCER — 6 months
Due to (or es e consequence of):
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Last:
b. Due to (or es e consequence of):
c. Due to (or es a consequence of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. **Did tobecco use contribute to the ceuse of death?** 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings eveileble prior to completion of ceuse of death? 1☐Yes 2☒No

25. Wes cese referred to medicel exeminer? 1☐Yes 2☒No

26. Place of Deeth (Check only one): Hospitel: 1☐Inpetient 2☒ER/Outpetient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 8☐Other (Specify)

27. Manner of Death: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28e. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29e. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the cause(s) and menner as stated. 2☐**Medical Examiner:** On the besis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) and menner steted.

29b. Signature end title of certifier: Enser W. Cole
29c. License number: D16354
29d. Dete signed (Month, Dey, Yeer): 12/31/97

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): Enser W. Cole, M.D., Bestgate Road, Suite 300, Annapolis, MD 21401

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 06 1998
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

AMEND: #7 & #8 1/6/98 mcg AA Co. Health

Reg. No. 97 41401

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Marilynn Eleanor Romo

2. Date of Death Month Day Year: December 27 1997

3. Time of Death: 7:35 AM

4a. Facility Name *(If not institution, give street and number)*: 1611 Harmony Acres Lane

4b. City, Town, or Location of Death: Annapolis

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 142-16-6176

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 74 ~~70~~ Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: ~~August 9, 1927~~ August 21, 1923

9. Birthplace *(State or Foreign Country)*: New Jersey

Usual Residence of Decedent

10a. State: Maryland

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1611 Harmony Acres Lane

10f. Zip Code: 21401

10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4or 5+): 5+

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Registered Nurse

16b. Kind of Business/Industry: Health Care

17. Father's Name *(First, Middle, Last)*:

18. Mother's Name *(First, Middle, Maiden Surname)*:

19a. Informant's Name/Relationship *(Type, Print)*: Leon Romo (husband)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1611 Harmony Acres Lane Annapolis, MD 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hillcrest Memorial Gardens

Date: Dec. 29, 1997

20c. Location - City or Town, State: Annapolis, MD

21. Signature of Funeral Service Licensee: Donald L. Sylvester

22. Name and Address of Facility: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cardiopulmonary disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Schmidlein MD

29c. License number: 030741

29d. Date signed *(Month, Day, Year)*: 12/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Jeffrey C. Schmidlein, M.D. 844 Ritchie Highway, #206 Severna Park, MD 21146

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41402

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: Fannie Dulaney Rowles

2. Dete of Deeth: Month 12 Dey 30 Yeer 1997

3. Time of Death: 0530 AM

4a. Facility Neme *(If not institution, give street end number)*: Prince Georges Hospital Center

4b. City, Town, or Location of Deeth: Cheverly

4c. County of Deeth: Prince Georges

Funeral Director

5. Social Security Number: 577 42 5783

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthdey)*: 97 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Feb/19/1900

9. Birthplece *(State or Foreign Country)*: Virginia

Usuel Residence of Decedent

10e. Stete: MD

10b. County: Prince Georges

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 203 Weymouth Street

10f. Zip Code: 20774

10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1☐ Never Merried 2☐ Merried 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Rece - Americen Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12) / College (1-4or 5+): 5+

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Government Employee

16b. Kind of Business/Industry: Federal Government

17. Fether's Neme *(First, Middle, Lest)*: William Abraham Dulaney

18. Mother's Neme *(First, Middle, Meiden Sumame)*: Ida Blanche Estes

19e. Informent's Name/Relationship *(Type, Print)*: Elaine Rowles (daughter in law)

19b. Mailing Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 203 Weymouth Street, Upper Marlboro MD 20774

20e. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Ft Lincoln Cemetery

Dete: 1/5/98

20c. Location - City or Town, Stete: Brentwood MD

21. Signature of Funerel Service Licensee: ▶ [signature]

22. Neme end Address of Feciliity: Advent Funeral Services, Annapolis MD 21401

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death): e. INTRACEREBRAL HEMMORHAGE 1 hr

Due to (or es e consequence of):

Sequentielly list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

b.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significent conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobecco use contribute to the ceuse of death? 1☐ Yes 2☐ No 3☐ Probebly 4☐ Unknown

24e. Wes en eutopsy performed? 1☐ Yes 2☐ No

24b. Were eutopsy findings eveilable prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes cese referred to medicel exeminer? 1☐ Yes 2☐ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☐ Nelurel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es stated. 2☐ **Medical Examiner**: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner stated.

29b. Signature end title of certifier: ▶ [signature] Attend Phys

29c. License number: D19897

29d. Dete signed *(Month, Dey, Yeer)*: 1.7.98

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): V. SINGH 7209 A HANOVER PARKWAY GREENBELT MD 2-770

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 02 1998

32. Registrer's Signeture: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Rowles Fannie

Coleridge Dr Arora

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41403

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Martin Schneider, Sr.

2. Date of Death Month Day Year: December 25, 1997

3. Time of Death: 8:25 PM

4a. Facility Name *(If not institution, give street and number)*: Genesis Eldercare, Layhill

4b. City, Town, or Location of Death: Silver Spring

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 396-32-5477

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

6. Data of Birth *(Month, Day, Year)*: Jan. 13, 1910

9. Birthplace *(State or Foraign Country)*: Romania

Usual Raisdance of Decedant

10a. State: Ohio

10b. County: Trumbull

10c. City, Town or Location: Niles

10d. Insida City Limits: 1 [X] Yas 2 [ ] No

10e. Street and Number: 152 Sayers Avenue

10f. Zip Code: 44446

10g. Citizan of What Country?: United States of America

11. Maritial Status: 1 [ ] Navar Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1 [ ] Yas 2 [XX] No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Race - Amarican indian, Black, White, atc. *Specify:* White

15. Decedant's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12): 8 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Painter

16b. Kind of Businass/Industry: Allied Metals Company

17. Fathar's Nama *(First, Middle, Last)*: Martin Schneider

18. Mothar's Nama *(First, Middle, Maiden Surname)*: Sofia Ruhrig

19a. Informant's Name/Ralationship *(Type, Print)*: Martha Allen

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2314 Twin Valley Lane, Silver Spring, MD 20906

20a. Mathod of Disposition: 1 [XX] Burial 2 [ ] Cramation 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Placa of Disposition *(Name of cemetery, crematory or other place)*: Niles City Cemetery

Data: Dec. 29, 1997

20c. Location - City or Town, Stata: Niles, Ohio

21. Signatura of Funaral Sarvice Licensee: ▶ Howard A Causey #M00690

22. Nama and Address of Facility: Holeton-Yuhasz Funeral Home, 126 West Park Avenue, Niles, Ohio 44446

Physician /Medical Examiner

23a. Part1. Entar tha disaasa, or complications that caused tha daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only ona causa on aach lina.

Approximata Intarval Batwaan Onsat and Daath: 2 weeks

Immadiata Causa (Finai disaase or condition rasulting in daath)

a. Pneumonia

Due to (or as a consequance of):

Sequantially list conditions, if any, laading to immadiata ceusa. Enter Undarlying Cause (Disaase or injury that initiated events rasulting in daath) Last

b. Renal insufficiency

Due to (or as a consaquance of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying ceusa givan in Part I.

History of Cerebro Vascular Accident

History of Vocal cord Tumor

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performad? 1 [ ] Yas 2 [X] No

24b. Wara autopsy findings available prior to compiation of ceusa of death? 1 [ ] Yes 2 [ ] No

25. Was cesa rafarrad to madical axaminar? 1 [ ] Yes 2 [X] No

28. Placa of Daath *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Rasidance 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Panding Invastigation 6 [ ] Could not be datarminad

28a. Data of Injury *(Month, Day Year)*

28b. Tima of injury

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1 [X] **Certifying Physician:** To tha bast of my knowiedge, deeth occurred at tha tima, data end place, and dua to the cause(s) and mannar as stated. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or Invastigation, in my opinion, daath occurred at the tima, data and place, and dua to the causa(s) and mannar statad.

29b. Signatura and title of certifiar: ▶ Wilhuim I. Nivala

29c. Licansa number: D 45285

29d. Data signed *(Month, Day, Year)*: December 26, 1997

30. Nama and address of person who completed ceusa of daath (Item 23a) (Type, Print): Dr W.J. Nivala, Silver Speing, Montgomery Co. MD.

State Registrar

31. Data filed *(Month, Day, Year)*: JAN 02 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41404

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: VIVIAN M. SIMMS

2. Date of Death Month / Day / Year: DEC. 31 1997

3. Time of Death: 0345

4e. Facility Name *(If not institution, give street and number)*: ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 219-16-0694

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 87 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: DEC. 4 1910

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ANNAPOLIS

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 12 BUNCHE STREET

10f. Zip Code: 21401

10g. Citizen of What Country?: US

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*

Elementary/Secondary (0-12): 12th

College (1-4or 5+): 2 yrs.

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: COOK

16b. Kind of Business/Industry: US NAVAL ACADEMY

17. Father's Name *(First, Middle, Last)*: WILLIAM CALVERT

18. Mother's Name *(First, Middle, Maiden Surname)*: RACHEL MILLER

19a. Informant's Name/Relationship *(Type, Print)*: ANNA HENSON (DAUGHTER) GRAND

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 54 PLEASANT STREET ANNAPOLIS, MD. 21401

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, cremetory or other place)*: ANNAPOLIS MEM. GARDENS

Date: 1/6/98

20c. Location - City or Town, State: ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee: ▶Harry B. Reese

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. pneumonia — one week

Due to (or as a consequence of):

b. Renal failure — one year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶Matthew Malta

29c. License number: D51819

29d. Date signed *(Month, Day, Year)*: December 31, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Matthew Malta 1833 A. Forest Drive, Annapolis, MD

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998

32. Registrar's Signature: ▶Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41405

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Charles Robert Smith
2. Date of Death Month Day Year: December 29, 1997
3. Time of Death: 10:15pm
4a. Facility Name *(If not institution, give street and number)*: Crofton Convalescent Center
4b. City, Town, or Location of Death: Crofton
4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 212-09-4167
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 83 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 14, 1914
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Anne Arundel
10c. City, Town or Location: Annapolis
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 602 College Parkway
10f. Zip Code: 21401
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 7 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Ship Fitter
16b. Kind of Business/Industry: Bethlehem Steel

17. Father's Name *(First, Middle, Last)*: Louis G. Smith
18. Mother's Name *(First, Middle, Maiden Surname)*: Beda Aschemeier

19a. Informant's Name/Relationship *(Type, Print)*: John Ronald Smith/son
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 604 College Parkway, Annapolis, MD 21401

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Asbury UMC Cemetery — Date: Jan 2 1998
20c. Location - City or Town, State: Arnold, MD

21. Signature of Funeral Service Licensee: ▶ [signature]
22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Chronic atrial fibrillation	6 months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b.	Left Cerebrovascular accident	6 months
Due to (or as a consequence of):		
c.	Seizures	6 months
Due to (or as a consequence of):		
d.	Hypertension	6 months

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death *(Check only one)*: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D40519
29d. Date signed *(Month, Day, Year)*: 12/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mirza Nusairee, M.D., 7845 Oakwood Road, Glen Burnie, MD 21061

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1998
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41406

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): George Anton Schmitt, Sr.

2. Date of Death (Month, Day, Year): December 25, 1997

3. Time of Death: 3:30 pm

4a. Facility Name (If not institution, give street and number): North Arundel Hospital

4b. City, Town, or Location of Death: Glen Burnie

4c. County of Death: Anne Arundel

Funeral Director

5. Social Security Number: 217-05-7068

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb 8, 1920

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Anne Arundel

10c. City, Town or Location: Severna Park

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10 Woodland Road

10f. Zip Code: 21146

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales Representative

16b. Kind of Business/Industry: Machine Shop

17. Father's Name (First, Middle, Last): Anton Schmitt

18. Mother's Name (First, Middle, Maiden Surname): Marie Zoellner

19a. Informant's Name/Relationship (Type, Print): Barbara Schmitt/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10 Woodland Road, Severna Park, MD 21146

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MD Veterans Cemetery

Date: Dec 29 1997

20c. Location - City or Town, State: Crownsville, MD

21. Signature of Funeral Service Licensee: John C. Barranco

22. Name and Address of Facility: Barranco & Sons, P.A. Severna Park Funeral Home, 495 Gov. Ritchie Hwy., Severna Park, MD 21146

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. A.S.C.V.D.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Cerebral Infarction

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☑ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Jose M. Presbitero MD

29c. License number: D 16208

29d. Date signed (Month, Day, Year): 1/5/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): JOSE M. PRESBITERO, M.D. 7845 OAKWOOD RD GLEN BURNIE MD 21061

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1998

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41407

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JAMES SUBER, JR.
2. Date of Death Month/Day/Year: Dec. 30 97
3. Time of Death: 4:20PM
4a. Facility Name (If not institution, give street end number): 2601 BEL PRE MEDLANTIC MANOR AT LAYHILL
4b. City, Town, or Location of Death: S.S. MD
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 251-20-1478
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JAN-29-26
9. Birthplace (State or Foreign Country): SOUTH CAROLINA

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: SILVER SPRING
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street end Number: 2601 BEL PRE RD
10f. Zip Code: 20906
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 10 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CONSTRUCTION WORKER
16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): JAMES Suber, Sr.
18. Mother's Name (First, Middle, Maiden Surname): Viola Howser

19a. Informent's Name/Relationship (Type, Print): PATRICIA WILLIAMSON / DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7900 SEVERN Hills Way, SEVERN, MD 21144

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): NoVa Crematory
Date: 1/9/98
20c. Location - City or Town, State: Arlington, VA.

21. Signature of Funeral Service Licensee: Roger J Mason
22. Name and Address of Facility: STERLING F.S. WASHINGTON, DC 20019

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
a. CARDIORESPIRATORY FAILURE — 5 DAYS

Due to (or as a consequence of):
b. CLOSED HEAD TRAUMA — 1 YR

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

Due to (or as a consequence of):
c. SEIZURE DISORDER — YEARS

Due to (or as a consequence of):
d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part i.
RIGHT UPPER LUNG MASS
GASTROINTESTINAL BLEEDING

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
26a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Cezar A. Lopez MD
29c. License number: D15405
29d. Date signed (Month, Day, Year): December 30, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CEZAR A. LOPEZ M.D. 18111 PRINCE PHILIP DRIVE OLNEY, MD

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1998
32. Registrar's Signature:

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(1)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41408

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Clarence Irvin Stack

2. Date of Death: Month 12 Day 31 Year 1997

3. Time of Death: 16:52

4a. Facility Name (If not institution, give street and number): 2401 Chancellors Point Rd.

4b. City, Town, or Location of Death: Trappe

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 577-28-0691

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 77 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 1,1920

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Prince George's

10c. City, Town or Location: Upper Marlboro

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 10601 Mattaponi Road

10f. Zip Code: 20772

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 1942-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 11 | College (1-4or 5+):

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Construction

17. Father's Name (First, Middle, Last): Fredrick Stack

18. Mother's Name (First, Middle, Malden Surname): Virginia Sauberlick

19a. Informant's Name/Relationship (Type, Print): June Stack/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10601 Mattaponi Rd. Upper Marlboro, Md. 20772

20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Name of cemetery, crematory or other place): St. Thomas Church Cem. Date: 1/3/98

20c. Location - City or Town, State: Upper Marlboro, Md.

21. Signature of Funeral Service Licensee: George P. Kalas

22. Name and Address of Facility: George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md.20745

Physician /Medical Examiner

23e. Part1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Arteriosclerotic Cardiovascular Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) Woods, Trappe, MD

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: David A. Stout, M.D.

29c. License number: D06804

29d. Date signed (Month, Day, Year): Jan. 1, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David Allan Stout, M.D. Memorial Hospital 219 S. Washington St.,Easton, MD 21601

State Registrar

31. Date filed (Month, Day, Year): JAN 05 1998

32. Registrar's Signature: Julie Dinsbar Randall

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

18

DHMH 16 Rev 6/95

RKD
97-1836-033
PERRY
SMOTHERS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41409
Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: PERRY SMOTHERS
2. Data of Death Month/Day/Year: DECEMBER 31, 1997
3. Time of Death: 2:30P.M.
4a. Facility Name *(If not institution, giva street and number)*: 6504 RONALD ROAD
4b. City, Town, or Location of Death: CAPITAL HEIGHTS
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 579-86-6608
6. Sex: 1 [X] M 2 [ ] F
7. Age *(in yrs. last birthday)*: 38 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Data of Birth *(Month, Day, Year)*: April 23, 1959
9. Birthplace *(State or Foreign Country)*: Bethesda, MD

Usual Residence of Decedent

10a. State: Maryland
10b. County: Prince George
10c. City, Town or Location: Capital Heights, MD
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 921 Opus Avenue
10f. Zip Code: 20743
10g. Citizen of What Country?: United States

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 11 / College (1-4or 5+):
16a. Decadant's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Laborer
16b. Kind of Business/Industry: Construction
17. Fethar's Nama *(First, Middle, Last)*: Louis Allen Smothers
18. Mother's Name *(First, Middle, Maiden Sumama)*: Sarah Morris
19a. Informant's Name/Relationship *(Type, Print)*: Sarah Smothers (Mother)
19b. Mailing Address *(Strael end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 921 Opus Avenue, Capital Heights, MD
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Name of cemetary, crematory or othar placa)*: Metropolitan Crematory
Date: 1/3/98
20c. Location - City or Town, State: Alexandria, VA
21. Signature of Funeral Service Licensea: Larry L. Simmons
22. Name and Address of Facility: Alexander S. Pope Funeral Home, 5538 Marlboro Pike, Forestville, MD 20747

Physician /Medical Examiner

23a. Part1. Enter the diseasa, or complications that causad tha daath. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on eech line.
Approximata Interval Between Onsat and Death

Immediate Causa (Final disaasa or condition resulting in deeth)
a. Acquired Immune deficiency Syndrome
Due to (or as a consequenca of):
b.
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in death) Last
Dua to (or as a consaquenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha underlying causa given in Part I.

23b. Did tobacco uss contributa to the causa of death? 1 [ ] Yss 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? INSPECTION 1 [ ] Yes 2 [X] No
24b. Were autopsy findings availabla prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examinar? 1 [X] Yes 2 [ ] No
26. Piece of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [X] Residanca 8 [ ] Other *(Specify)*
27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Dey Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yas 2 [ ] No
28d. Describe how Injury occurred
28e. Placa of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*
28f. Location *(Street end Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician**: To tha best of my knowledga, daath occurred at tha tima, data and placa, and due to tha causa(s) and mannar as stated. 2 [X] **Medical Examiner**: On tha basis of examination end/or investigation, in my opinion, daath occurred at the tima, data and placa, and dua to tha causa(s) and manner stated.
29b. Signature and titie of certifiar
29c. License number: O.C.M.E.
29d. Deta signed *(Month, Day, Year)*: JANUARY 1, 1998
30. Name and address of person who compiated causa of death (Item 23a) (Type, Print): David R Fowler, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed *(Month, Day, Yeer)*: JAN 05 1998
32. Registrar's Signature: Julia Henderson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41410

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILBUR W. THOMPSON

2. Date of Death (Month, Day, Year): DEC. 30 1997

3. Time of Death: 1559

4a. Facility Name *(If not institution, give street and number)*: ANNE ARUNDEL MEDICAL CENTER

4b. City, Town, or Location of Death: ANNAPOLIS

4c. County of Death: ANNE ARUNDEL

Funeral Director

5. Social Security Number: 220-01-5039

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 84 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: AUG. 8 1913

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: ANNE ARUNDEL

10c. City, Town or Location: ANNAPOLIS

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 123 EASTERN AVENUE

10f. Zip Code: 21403

10g. Citizen of What Country?: US

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+): 1 yr.

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: COOK

16b. Kind of Business/Industry: US NAVAL ACADEMY

17. Father's Name *(First, Middle, Last)*: JAMES B. THOMPSON

18. Mother's Name *(First, Middle, Maiden Surname)*: BERTHA TURNER

19a. Informant's Name/Relationship *(Type, Print)*: SANDRA SOLOMON (DAUGHTER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 64 EMERSON RD. CASTLE CREEK, NY. 13744

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ANNAPOLIS MEM. GARDENS Date: 1/5/98

20c. Location - City or Town, State: ANNAPOLIS, MD.

21. Signature of Funeral Service Licensee: Harry D. Reese

22. Name and Address of Facility: WM. REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Heart block - complete	Immed
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Prostate cancer - metastatic	Yrs
Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Dementia - Multi-infarct

COPD

CHF

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Joseph N Friend M.D

29c. License number: 017965

29d. Date signed *(Month, Day, Year)*: 12/31/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Joseph N Friend 205 Ridgely Ave Annapolis, md

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

RKD

97-1714-033

MARCUS THOMPSON

ITEMS: 29d. & 28.A-F PER MEO P.G.C. 1-7-98 cr

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41411

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Marcus L. Thompson

2. Date of Death: Month DECEMBER Day 30, Year 1997

3. Time of Death: 3:49P.M.

4a. Facility Name (If not Institution, give street and number): PRINCE GEORGES HOSPITAL

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 214-19-9099

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 15 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 3/3/82

9. Birthplace (State or Foreign Country): Wash., D.C.

Usual Residence of Decedent

10a. State: Md.

10b. County: P.G.

10c. City, Town or Location: Temple Hills

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3503 26th Ave.

10f. Zip Code: 20748

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indien, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student

16b. Kind of Business/Industry: School

17. Father's Name (First, Middle, Last): Unknown

18. Mother's Name (First, Middle, Meiden Surname): Carol Thompson

19a. Informant's Name/Relationship (Type, Print): Carol Thompson/Mother

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): Same as # 10 above

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Piece of Disposition (Neme of cemetery, cremetory or other piece): Harmony Mem. Park Date: 1/5/98

20c. Location - City or Town, State: Landover, Md.

21. Signeture of Funeral Service Licensee: ▶ Larry W. Pratt

22. Name and Address of Facility: H.S.Washington & Sons Co.,Inc. 4925 Burroughs Ave.,N.E.

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Deeth

Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound of Head

Due to (or as a consequence of):

Sequentielly list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobecco use contribute to the ceuse of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Menner of Death: 1 [ ] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year): 12-29-97

28b. Time of Injury: 7:00 P M

28c. Injury et Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: SUBJECT WAS SHOT

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): STREET

28f. Location (Street end Number or Rural Route Number, City or Town, State): 2800 BLK. IVERSON STREET-TEMPLE HILLS, MD

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred et the time, dete end place, and due to the cause(s) end manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Dennis J. Chute MD

29c. License number: O.C.M.E.

29d. Dete signed (Month, Day, Year): JANUARY 1, ~~1997~~ 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1998

32. Registrar's Signature: Jabi Mudeer Rahal

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41412
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): JOHN TAYLOR
2. Date of Death (Month, Day, Year): DEC 29, 1997
3. Time of Death: 10:15AM
4a. Facility Name (If not institution, give street and number): HOLY CROSS HOSPITAL
4b. City, Town, or Location of Death: SILVER SPRING, MD
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 256 12 0118
8. Sex: 1☐ M 2☐ F X
7. Age (In yrs. last birthday): 78 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT 21, 1919
9. Birthplace (State or Foreign Country): GEORGIA

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: WHEATON
10d. Inside City Limits: X 1☒ Yes 2☐ No
10e. Street and Number: 11512 BUCKNELL DRIVE
10f. Zip Code: 20902
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Year or Dates: 1942-1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SUPERVISOR
16b. Kind of Business/Industry: GOVERNMENT

17. Father's Name (First, Middle, Last): WILLIAM TAYLOR
18. Mother's Name (First, Middle, Maiden Surname): LUCY IRVIN

19a. Informant's Name/Relationship (Type, Print): LELIA TAYLOR (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11512 BUCKNELL DRIVE, WHEATON, MD 20902

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetary, crematory or other place): LINCOLN MEMORIAL
Date: JAN 3, 1998
20c. Location - City or Town, State: SUITLAND, MD

21. Signature of Funeral Service Licensee: Ralph Williams
22. Name and Address of Facility: RALPH WILLIAMS FUNERAL SVC, 517 11th STREET S.E.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE — 20+ YRS.

Due to (or as a consequence of):
b. CHRONIC PANCREATITIS WITH MALABSORPTION — 20+ YRS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. ALZHEIMER'S DEMENTIA — 3 YRS.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier
29c. License number: DC-4360
29d. Date signed (Month, Day, Year): 12/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAH YOO, M.D. 1160 VARNUM ST., N.W. #217, WASH. DC 20017

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1998
32. Registrar's Signature: Julia Anderson Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41413

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ralph Thomas

2. Date of Death — Month: 12 Day: 28 Year: 1997

3. Time of Death: 12 16 AM

4a. Facility Name *(If not institution, give street and number)*: Laurel Regional Hospital

4b. City, Town, or Location of Death: Laurel

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 241-14-9850

6. Sex: 1 ☒ M 2 ☐ F

7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: November 28, 1917

9. Birthplace *(State or Foreign Country)*: North Carolina

Usual Residance of Decedent

10a. State: Maryland

10b. County: Prince George's

10c. City, Town or Location: Greenbelt

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 7820 Hanover Parkway #304

10f. Zip Code: 20770

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Navar Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. Was Decedant Evar in U.S. Armed Forcas? 1 ☒ Yas 2 ☐ No — If Yas, Giva Yaar or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1 ☐ Yas 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, atc. *Specify:* Black

15. Decedent's Education *(Specify only highast grada complatad)* — Elementary/Sacondary (0-12): 5th grade — Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Laborer

16b. Kind of Business/Industry: Construction

17. Fathar's Name *(First, Middle, Last)*: Paul Thomas

18. Mothar's Nama *(First, Middle, Maidan Surnama)*: Sadie McCain

19a. Informant's Name/Raiationship *(Type, Print)*: Mrs. Joyce Ann Harrington (Niece)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7820 Hanover Parkway #304 Greenbelt, Maryland 20770

20a. Mathod of Disposition: 1 ☐ Burial 2 ☒ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar *(Spacify)*

20b. Placa of Disposition *(Nama of camatary, cramatory or othar placa)*: Chesapeake Crematory, Inc.

Data: 1/7/98

20c. Location - City or Town, Stata: Beltsville, Maryland

21. Signatura of Funeral Service Licensaa: Janet C. Anderson

22. Nama and Address of Facility: Rollins Funeral HOme, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019

Physician /Medical Examiner

23a. Part I. Enter the diaasa, or complications that caused tha death. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only ona causa on aach line.

		Approximata Interval Batwaan Onsat and Daath
Immediata Ceuse (Final disaasa or condition resulting in death) a.	Pneumonia	24 hours
Dua to (or as a consequanca of): b.	Cerebrovasculer Accident	3 years
Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Diseese or Injury that initiated avents rasulting in daath) Last — Dua to (or as a consequance of): c.		
d.		

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performad? 1 ☐ Yas 2 ☒ No

24b. Wara autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was casa rafarrad to medical examiner? 1 ☐ Yas 2 ☒ No

26. Placa of Daath *(Check only ona)* — Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — Othar: 4 ☐ Nursing Hama 5 ☐ Rasidanca 8 ☐ Othar *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicida 4 ☐ Homicida 5 ☐ Panding Investigation 6 ☐ Could not be datarmined

28a. Data of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Dascribe how injury occurred

28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, Stata)*

29a. Cartifier *(Check only one)*: 1 ☒ **Certifying Physician:** To tha best of my knowledge, daath occurrad at tha tima, data and placa, and dua to tha cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, daath occurrad at the tima, data and placa, and dua to the causa(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D25430

29d. Data signed *(Month, Day, Year)*: 12/28/97

30. Nama and address of parson who completed cause of daath (Item 23a) (Type, Print): 14333 Laurel Bowie Rd #307 Laurel, MD 20708 John Margolis

State Registrar

31. Data filed *(Month, Day, Yaar)*: JAN 05 1998

32. Registrar's Signatura: [signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41414

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: ALONZO LEE TERRY
2. Dete of Deeth (Month, Dey, Yeer): DECEMBER 30, 1997
3. Time of Deeth: 9:30 am
4a. Feclity Neme *(If not institution, give street end number)*: 8801 ROSEANNA CT
4b. City, Town, or Location of Death: CLINTON
4c. County of Deeth: P.G. COUNTY

Funeral Director

5. Social Security Number: 232-66-0142
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthdey)*: 57 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Dete of Birth *(Month, Dey, Yeer)*: JUNE 24, 1940
9. Birthplece *(Stete or Foreign Country)*: WEST VIRGINIA

Usuel Residence of Decedent

10e. Stete: MD
10b. County: P.G COUNTY
10c. City, Town or Location: CLINTON
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 8801 ROSEANNE CT
10f. Zip Code: 20735
10g. Citizen of Whet Country?: USA

11. Meritel Stetus: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1 [ ] Yes 2 [ ] No If Yes, Give Year or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.): 1 [ ] Yes 2 [X] No *Specify:*
14. Reca - Americen Indien, Bleck, White, etc. *Specify:* BLACK
15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12); College (1-4or 5+): 2
16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: MANAGEMENT ANALYST
16b. Kind of Business/Industry: GOVERNMENT
17. Fether's Neme *(First, Middle, Last)*: JOSEPH TERRY
18. Mother's Neme *(First, Middle, Melden Surneme)*: LOUISE MONROE
19e. Informent's Neme/Relationship *(Type, Print)*: FRANCES TERRY /WIFE
19b. Meiling Address *(Street end Number or Rurel Route Number, City or Town, Stete, Zip Code)*: 8801 ROSEANNA CT CLINTON MD 20735
20e. Method of Disposition: 1 [X] Burial 2 [ ] Cremetion 3 [ ] Removel from State 4 [ ] Donetion 5 [ ] Other *(Specify)*
20b. Piece of Disposition *(Neme of cemetery, cremetory or other pleca)*: MARYLAND VETERANS
Dete: 1-6-98
20c. Location - City or Town, Stete: CHELTENHAM MD
21. Signeture of Funerel Servica Licensee: Joyce Montgomery-Cheatham
22. Neme and Address of Facility: ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE FORESTVILLE MD 20747

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert feilure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediete Ceuse (Finel diseese or condition resulting in death): e. ACUTE MYOCARDIAL INFARCTION
Due to (or es e consequenca of):
Sequentially list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest:
b.
Due to (or es e consequence of):
c.
Due to (or es e consequenca of):
d.

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobacco use contribute to the cause of deeth?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24e. Wes en eutopsy performed?: 1 [X] Yes 2 [ ] No
24b. Were eutopsy findings eveileble prior to completion of cause of deeth?: 1 [X] Yes 2 [ ] No

25. Was case referred to medical exeminer?: 1 [X] Yes 2 [ ] No
26. Piece of Deeth *(Check only one)*: Hospitel: 1 [ ] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [X] Residenca 6 [ ] Other *(Specify)*
27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28e. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury: M
28c. Injury et Work?: 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Street end Number or Rurel Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2 [X] **Medical Examiner**: On the basis of exemineticn end/or investigetion, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: David M Issac
29c. License number: D 24289
29d. Dete signed *(Month, Dey, Yeer)*: 1/2/98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): David Issac 5001 Silver Hill Rd Suite 101 Suitland MD 20746

State Registrar

31. Dete filed *(Month, Day, Yeer)*: JAN 05 1998
32. Registrer's Signeture: John Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41415

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: May Taylor

2. Date of Death Month/Day/Year: 12/28/97

3. Time of Death: 10:55 Am.

4a. Facility Name *(If not institution, give street and number)*: Regency health care center

4b. City, Town, or Location of Death: Forestville

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 577-80-0341

6. Sex: 1☐ M 2☑ F

7. Age *(In yrs. last birthday)*: 85 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 12-11-12

9. Birthplace *(State or Foreign Country)*: Panama

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: md

10b. County: P.G. County

10c. City, Town or Location: Forestville

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6804 Keystone Manor Ct.

10f. Zip Code: 20747

10g. Citizen of What Country?: Panama

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Panamanian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Housewife

16b. Kind of Business/Industry: Private

17. Father's Name *(First, Middle, Last)*: Scott Thorpe

18. Mother's Name *(First, Middle, Maiden Surname)*: Violet Jarrett

19a. Informant's Name/Relationship *(Type, Print)*: Ana C. Pannell /Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6804 Keystone Manor Ct.,Forestville,Md. 20747

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resurrection Cemetery

Date: 1/3/98

20c. Location - City or Town, State: Clinton,Md.

21. Signature of Funeral Service Licensee: Alex S. Pope Jr M859

22. Name and Address of Facility: ALEXANDER S. POPE FUNERAL HOMES 5538 Marlboro Pike.,Forestville,Md.20747

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseasa, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Fatal Arrhythmia — 5 mins

Due to (or as a consequence of):

b. Congestive Myocardiopathy — 1-2 yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Cardiomegaly, Diabetes, High Blood pressure

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Richard A. Farson, MD

29c. License number: D02237 MD

29d. Date signed *(Month, Day, Year)*: 12/28/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Richard A. Farson MD, 12825 Old Fort Rd Ft. Wash MD 20744

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998

32. Registrar's Signature: [signature]

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

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(4)

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41416

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): FAITH HELEN TAYLOR
2. Date of Death Month Day Year: DECEMBER 26, 1997
3. Time of Death: 12:55 AM
4a. Facility Name (If not institution, give street and number): PRINCE GEORGE'S COUNTY HOSPITAL
4b. City, Town, or Location of Death: CHEVERLY
4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 212-22-9734
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 19, 1922
9. Birthplace (State or Foreign Country): VIRGINIA

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: PRINCE GEORGE'S
10c. City, Town or Location: CAPITOL HEIGHTS
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1111 BOOKER DRIVE
10f. Zip Code: 20742
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): UNKNOWN; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FOOD SERVER
16b. Kind of Business/Industry: NONPROFIT ORGANIZATION

17. Father's Name (First, Middle, Last): JAMES ROBINSON
18. Mother's Name (First, Middle, Maiden Surname): MILDRED PINKETT

19a. Informant's Name/Relationship (Type, Print): MARIETTA SHARPERSON, DAUGHTER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3107 GOOD HOPE AVE., #314, TEMPLE HILLS, MD 20748

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): FORT LINCOLN CEMETERY
Date: 1/2/98
20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: Lisa S. Johnson
22. Name and Address of Facility: FORT LINCOLN FUNERAL HOME, 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Small Cell Carcinoma of Lung c Metastasis
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Dehydration
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypertensive Cardiovascular disease.
Diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: H. A. Molavi, MD
29c. License number: D12861
29d. Date signed (Month, Day, Year): 1.8.98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): H.A. MOLAVI, M.D., 6005 LANDOVER ROAD, SUITE 1, CHEVERLY, MARYLAND 20785

State Registrar

31. Date filed (Month, Day, Year): JAN 09 1998
32. Registrar's Signature:

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41417

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): R Reynold Wilson
2. Date of Death Month Day Year: December 29, 1997
3. Time of Death: 1515
4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 219-30-5712
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 78 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): JULY 27, 1919
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: CROWNSVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 1069 GENERALS HWY.
10f. Zip Code: 21032
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): TAX ASSESSOR
16b. Kind of Business/Industry: STATE OF MARYLAND

17. Father's Name (First, Middle, Last): ARCHIE HAMILTON WILSON
18. Mother's Name (First, Middle, Maiden Surname): MILDRED FEATHERS

19a. Informant's Name/Relationship (Type, Print): DORIS ANN WILSON (WIFE)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1069 GENERALS HWY., CROWNSVILLE, MARYLAND 21032

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BALDWIN MEMORIAL CHURCH CEMETERY
Date: 1/3/98
20c. Location - City or Town, State: CROWNSVILLE, MD

21. Signature of Funeral Service Licensee: Michael C. Jaffin
22. Name and Address of Facility: SINGLETON FUNERAL HOME, 1 SECOND AVE. S.W., GLEN BURNIE, MD 21061

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Probable Carcinomatous Meningitis — one month

Due to (or as a consequence of):
b. Carcinoma of Unknown Primary — six months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus
Atrial Fibrillation

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Donald A. Dibbern, Jr., MD
29c. License number: RES-000
29d. Date signed (Month, Day, Year): December 29, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Donald A. Dibbern, Jr., MD, Johns Hopkins Hospital, 601 N Wolfe Street, Baltimore, MD 21205

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41418

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: ELISABETH K. WOODWARD

2. Dete of Deeth — Month: December; Dey: 30; Year: 1997

3. Time of Deeth: 8:55 PM

4e. Feciity Neme *(If not institution, give street end number)*: Annapolis Nursing & Rehab. Center

4b. City, Town, or Location of Deeth: Annapolis

4c. County of Deeth: Anne Arundel

Funeral Director

5. Social Security Number: 216-44-6200

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. lest birthday)*: 78 Yrs.

If Under 1 Yeer — Months: ; Deys:

If Under 24 Hrs. — Hours: ; Min.:

8. Dete of Birth *(Month, Dey, Yeer)*: Sept. 1,1919

9. Birthpiece *(Stete or Foreign Country)*: S. Carolina

Usuel Residence of Decedent

10e. Stete: Md.

10b. County: Anne Arundel

10c. City, Town or Location: Annapolis

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 701 Glenwood Rd. Apt. 610

10f. Zip Code: 21401

10g. Citizen of Whet Country?: USA

11. Meritel Status: 1☐ Never Merried 2☐ Married 3☒ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Rece - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 12; College (1-4or 5+):

16e. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Licensed Practical Nurse

16b. Kind of Business/Industry: Nursing

17. Fether's Neme *(First, Middle, Last)*: James B. King

18. Mother's Name *(First, Middle, Meiden Sumeme)*: Victoire Soubeyfoux

19e. Informent's Neme/Reletionship *(Type, Print)*: Elizabeth L. Hammond

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 93 Quarter Landing Rd. Annapolis, Md. 21403

20e. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from Stete 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Ft. Lincoln Crematory

Dete: 1-2-98

20c. Location - City or Town, State: Brentwood, Md.

21. Signeture of Funerel Service Licensee: [signature]

22. Neme end Address of Feciity: John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, Md. 21401

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immediete Cause (Finel diseese or condition resulting in deeth): e. CVA

Due to (or as a consequence of):

Sequentielly list conditions, if eny, leading to immediete ceuse. Enter Underlying Cause (Diseese or Injury thet Initieted events resulting in deeth) Lest:

b. HTN

Due to (or es e consequence of):

c. Atrial Fibrillation

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert t.: Dementia

23b. **Did tobacco use contribute to the cause of death?** 1☐ **Yes** 2☒ **No** 3☐ **Probably** 4☐ **Unknown**

24e. Wes en autopsy performed? 1☐ Yes 2☒ No

24b. Were eutopsy findings eveileble prior to completion of ceuse of death? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*:

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred:

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)*:

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*:

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) end menner es steted. 2☐ **Medicel Exeminer:** On the basis of exemineticn end/or investigetion, in my opinion, deeth occurred et the time, date end piece, and due to the ceuse(s) end menner stated.

29b. Signeture end title of certifier: Lisa Murray MD

29c. License number: D385260

29d. Dete signed *(Month, Dey, Yeer)*: 12/31/97

30. Neme and eddress of person who completed ceuse ot deeth (Item 23e) (Type, Print): LISA MURRAY, MD 1600 Ridgley Ave S120 Annapolis MD 21401

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 06 1998

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

6 0/6

Reg. No. 97 41419

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Julius Arvis Warnza

2. Date of Death (Month, Day, Year): 12-31-97

3. Time of Death: 11:10am

4a. Facility Name (If not institution, give street and number): MANOR CARE NURSING HOME

4b. City, Town, or Location of Death: Largo

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 383-09-8205

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 78 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): June 9,1919

9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Forestville

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3237 Prince Ranier Place

10f. Zip Code: 20747

10g. Citizen of What Country?: United States

11. Maritel Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: 42-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Mail Carrier

16b. Kind of Business/Industry: Federal Government

17. Father's Name (First, Middle, Last): Unk

18. Mother's Name (First, Middle, Meiden Surneme): Unk

19a. Informant's Name/Relationship (Type, Print): Carlette W. Warren / Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3237 Prince Ranier Place, Forestville, Md 20747

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park

Date: 1/9/98

20c. Location - City or Town, State: Landover, Maryland

21. Signature of Funeral Service Licensee: [signature] M859

22. Name and Address of Facility: POPE FUNERAL HOMES 2617 Pennsylvania Avenue, SE DC 20020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Finel disease or condition resulting in death)

a. Mutiorgam feilure — 1 day

Due to (or as a consequence of):

b. COPD

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I.

ASHD

Hypertension

Dementia

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes an eutopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of deeth? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Deeth: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Phyalcian: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and menner es stated. 2 [ ] Medical Examiner: On the basis of examination end/or Investigetion, In my opinion, death occurred at the time, dete and piece, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: [signature] VARKEY MATHEW

29c. License number: D45435

29d. Date signed (Month, Day, Year): 1/2/98

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print): Suit 301 110 Hosp Rd Prince Frederick MD 20678

State Registrar

31. Date filed (Month, Day, Year): JAN 08 1998

32. Registrar's Signature: [signature]

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41420

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David Williams

2. Date of Death (Month, Day, Year): Dec. 17, 1997

3. Time of Death: 3:15PM

4a. Facility Name (If not institution, give street and number): 8409 Hamlin St. #103

4b. City, Town, or Location of Death: Lanham

4c. County of Death: Prince George

Funeral Director

5. Social Security Number: 250-52-5927

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 64 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Sept. 26, 1933

9. Birthplace (State or Foreign Country): Sumter, SC

Usual Residence of Decedent

10a. State: Maryland

10b. County: Prince George

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3262 Queenstown Drive, #302

10f. Zip Code: 20712

10g. Citizen of What Country? United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cement Finisher

16b. Kind of Business/Industry: John Hamilton Construction Co.

17. Father's Name (First, Middle, Last): Thomas Williams

18. Mother's Name (First, Middle, Maiden Surname): Jesse Brunson

19a. Informant's Name/Relationship (Type, Print): Carrie M. Williams (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3262 Queenstown Drive #302 Hyattsville, MD 20712

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Memorial Park

Date: 12/27/97

20c. Location - City or Town, State: Landover, MD

21. Signature of Funeral Service Licensee: John W. Latney Jr.

22. Name and Address of Facility: Latney's Funeral Home, Inc. 3831 Georgia Ave, NW Wash, DC 20011

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

CR

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Lung Cancer — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I: Brain Metastases

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Relative Home

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James Louis Davis

29c. License number: 10206

29d. Date signed (Month, Day, Year): Dec. 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James Louis Davis 1700 17th St. NW Washington, DC 20009

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(6)

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1998

32. Registrar's Signature: Judi Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41421

Amended # 18, P.G.C. 1/8/98 cr

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: ALMA M. WHITE

2. Date of Death (Month, Day, Year): DECEMBER 12, 1997

3. Time of Death: 2:10 AM

4a. Facility Name *(If not institution, give street and number)*: GLADYS SPELLMAN NURSING CENTER

4b. City, Town, or Location of Death: CHEVERLY

4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 577-42-8293

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: APR. 18, 1908

9. Birthplace *(State or Foreign Country)*: WASHINGTON, D.C.

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: PRINCE GEORGE'S

10c. City, Town or Location: CHEVERLY

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6219 FOREST ROAD

10f. Zip Code: 20785

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: HOUSEWIFE

16b. Kind of Business/Industry: OWNED HOME

17. Father's Name *(First, Middle, Last)*: GEORGE P. STOKES

18. Mother's Name *(First, Middle, Maiden Surname)*: ALICE ~~WHITE~~ PYLES

19a. Informant's Name/Relationship *(Type, Print)*: ALMA McKENNA, DAUGHTER

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5819 DEWEY STREET, CHEVERLY, MARYLAND 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: FORT LINCOLN CEMETERY

Date: 12/16/97

20c. Location - City or Town, State: BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee: Lisa S. Johnson

22. Name and Address of Facility: FORT LINCOLN FUNERAL HOME 3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. RENAL FAILURE

Due to (or as a consequence of):

c. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

d. RECURRENT SEPSIS

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

ANEMIA OF CHRONIC DISEASE

HYPERTENSION

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D34722

29d. Date signed *(Month, Day, Year)*: DECEMBER 24, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): VICKEN K. POOCHIKIAN, M.D., 5632 ANNAPOLIS RD., BLADENSBURG, MD 20710

(10)

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998

32. Registrar's Signature

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41422

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MONROE WILLIAMSON
2. Date of Death Month / Day / Year: DECEMBER 28 1997
3. Time of Death: 12:39 P.M.
4a. Facility Name *(If not institution, give street and number)*: MALCOLM GROW MEDICAL CENTER
4b. City, Town, or Location of Death: CAMP SPRINGS
4c. County of Death: PRINCE GEORGE'S

Funeral Director

5. Social Security Number: 248-44-5410
6. Sex: 1☒ M 2☐ F
7. Age *(In yrs. last birthday)*: 68 Yrs.
If Under 1 Yaar: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: APRIL 9,1929
9. Birthplace *(State or Foreign Country)*: COLUMBIA SC

Usual Residence of Decedent

10a. State: MD
10b. County: P.G COUNTY
10c. City, Town or Location: CAMP SPRINGS
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 5111 CLACTON AVE
10f. Zip Code: 20746
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Naver Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☒ Yes 2☐ No If Yes, Give Yaar or Datas:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Raca - American Indian, Black, White, atc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grada completed)*: Elementary/Secondary (0-12): 12 / Collega (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: SOLDIER
16b. Kind of Business/Industry: U.S. ARMY

17. Father's Name *(First, Middle, Last)*: RICHARD WILLIAMSON
18. Mother's Nama *(First, Middle, Maiden Sumama)*: ADA WASHINGTON

19a. Informent's Neme/Relationship *(Type, Print)*: RACHEL WILLIAMSON/WIFE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5111 CLACTON AVE CAMP SPRINGS MD 20746

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from Stata 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Nama of cemetery, crematory or other placa)*: ARLINTON NATIONAL CEMETRY
Date: 1-9-98
20c. Location - City or Town, Stata: ARLINGTON VA

21. Signature of Funaral Service Licensaa: George Montgomery-Chesthom
22. Name and Address of Facility: ALEXANDER S. POPE FUNERAL HOME 5538 MARLBORO PIKE FORESTVILLE MD 20747

To Be Completed by Funeral Director

MONROE WILLIAMSON
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. CARDIAC ARRHYTHMIA / ASYSTOLE — 40 MIN

Due to (or as a consequence of):
b. PNEUMONIA — 6 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. CARDIAC ISCHEMIA — 6 DAYS

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: George E. Gibbons, MAJ, USAF, MC, Chief, Surgical Pathology, MGMC, 89th MG, Andrews AFB, MD 20762-6600 George Gibbons M.D
29c. Licensa number: MD 055052-L
29d. Date signed *(Month, Day, Year)*: DECEMBER 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GEORGE E. GIBBONS,MAJ,USAF,MC
89 MDG 1050 W. PERIMETER ROAD ANDREWS AFB, MD 20762-6600

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998
32. Registrar's Signature:

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(10)

DHMH 16 Rev 6/95

George E. Gibbons, Maj, USAF, MC
Chief, Surgical Pathology, MDMC
83rd MG, Andrews AFB, MD 20762-6600

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41423

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): LILLIAN WARREN
2. Date of Death (Month, Day, Year): Dec. 27 1997
3. Time of Death: 7:41 AM
4a. Facility Name (If not institution, give street and number): HEARTLAND HEALTH CARE CENTER
4b. City, Town, or Location of Death: HYATTSVILLE
4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 579-18-3723
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Oct. 8, 1916
9. Birthplace (State or Foreign Country): Washington, DC

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Temple Hills
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2004 Gaither St.
10f. Zip Code: 20748
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Foster Care
16b. Kind of Business/Industry: Pvt Family Child Svc.

17. Father's Name (First, Middle, Last): UNKNOWN
18. Mother's Name (First, Middle, Maiden Surname): UNKNOWN

19a. Informant's Name/Relationship (Type, Print): Dereck Warren/ Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2004 Gaither St. Temple Hills, Md. 20748

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Metropolitan Crematory
Date: 12-30-97
20c. Location - City or Town, State: Alexandria, VA.

21. Signature of Funeral Service Licensee: Kimberly Chestnut
22. Name and Address of Facility: Marshall's Funeral Home, Inc. of Maryland 4308 Suitland Rd. Suitland, MD. 20746

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

CR

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Atherosclerosis Cardiovascular Disease — 12 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☒ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Paul A. DeVore
29c. License number: D04988
29d. Date signed (Month, Day, Year): 12/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Paul A. DeVore, MD 4203 Queensbury Road Hyattsville MD 20781

State Registrar

31. Date filed (Month, Day, Year): JAN 05 1998
32. Registrar's Signature: John Thurston Kendall

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

(6)

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41424

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Walker

2. Date of Death (Month, Day, Year): Dec. 24, 1997

3. Time of Death: 1:20 pm

4a. Facility Name (If not institution, give street and number): Southern Maryland Hospital

4b. City, Town, or Location of Death: Clinton

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-07-5811

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 92 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 13, 1904

9. Birthplace (State or Foreign Country): Orangeburg SC

Usual Residence of Decedent

10a. State: MD

10b. County: PG

10c. City, Town or Location: Clinton

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 9211 Stewart Lane

10f. Zip Code: 20735

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elemantary/Secondary (0-12): 8th. Collaga (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Chef

16b. Kind of Business/Industry: Restaurant

17. Father's Name (First, Middle, Last): Elisha Walker

18. Mother's Name (First, Middle, Maiden Surneme): MAry Jane Tobin

19a. Informant's Name/Ralationship (Type, Print): Aubrey Colter Nephew

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda): 2602 Millsboro Ct. Forestville, Md. 20747

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cramation 3 [ ] Removal from Stata 4 [ ] Donation 5 [ ] Other (Specify)

20b. Placa of Disposition (Neme of cemetary, cremetory or other piece): Md. NAtional Memoriall Data: 1-5-98

20c. Location - City or Town, State: Laurel, Md.

21. Signature of Funaral Service Licansaa: Julia P. Marshall

22. Name and Address of Facility: MArshall's Funeral Home 4217 9th. St. N.W. Wash. D.C. 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused tha daath. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ona cause on each line.

Approximata Interval Between Onsat and Death

Immediate Cause (Final diseasa or condition rasulting in death): a. Acute Exacerbation of Chr Lung 72h

Due to (or as a consequenca of): b. Dehydration, Malnutrition 2wks

Sequentially list conditions, if any, leading to immadiate causa. Entar Underlying Cause (Diseasa or Injury that initiated evants resulting in death) Last: Due to (or as a consequance of): c.

Due to (or as a consequence of): d.

Part II. **Othar significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [X] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to complation of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examinar? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residance 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Panding Invastigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Deacribe how injury occurred

28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Spacify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Cartifier (Check only one): 1 [X] **Certifying Phyaician:** To the best of my knowledge, daath occurred at tha time, date and placa, and dua to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at tha time, date and place, and due to the causa(s) and mannar stated.

29b. Signature and title of certifier: MD Attende

29c. License number: D-24535

29d. Data signed (Month, Dey, Yaar): 12.26.97

30. Name and eddress of person who completed causa of daath (Item 23a) (Type, Print): Lakmi N. Berwa MD. 7300 Old Branch Ave. E-101 Clinton MD 20735

State Registrar

31. Date filed (Month, Dey, Yaar): JAN 05 1998

32. Registrar's Signature: John Thompson Rockwell

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41425

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Beulah Mae Waller

2. Date of Death: Month December Day 24 Year 1997

3. Time of Death: 2:10 PM

4a. Facility Name (If not institution, give street and number): Prince Georges Hospital

4b. City, Town, or Location of Death: Cheverly

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 227-05-8451

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 85 Yrs.

If Under 1 Year: Months ____ Days ____

If Under 24 Hrs.: Hours ____ Min. ____

8. Date of Birth (Month, Day, Year): March 6 1912

9. Birthplace (State or Foreign Country): Virginia

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Landover

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 7615 Allendale Dr.

10f. Zip Code: 20785

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 8th; College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Private

17. Father's Name (First, Middle, Last): William B. Womack

18. Mother's Name (First, Middle, Maiden Surname): Lemon Medley

19a. Informant's Name/Relationship (Type, Print): Sherry Waller Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1613 Village Green Dr. Landover, MD 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Triumph Baptist Church

Date: 12-29

20c. Location - City or Town, State: Chatham, VA.

21. Signature of Funeral Service Licensee: J. P. Marshall

22. Name and Address of Facility: Marshall's Funeral Home, Inc. 4217 9th St. NW Washington, DC 20011

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. POSSIBLE PULMONARY EMBOLISM — 1 month

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ____

Due to (or as a consequence of):

c. ____

Due to (or as a consequence of):

d. ____

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Hypertensive

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: R Bhojraj MD

29c. License number: D23181

29d. Date signed (Month, Day, Year): 12-24-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): R G BHOJRAJ MD 704 GORMAN AVE #T-1 LAUREL, MD 20707

State Registrar

31. Date filed (Month, Day, Year): JAN 05 1998

32. Registrar's Signature: Julia Blackpar Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

(6)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41426

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Steven Hiram Allison-Newman
2. Date of Death Month / Day / Year: December 24, 97
3. Time of Death: 6:15 PM
4a. Facility Name *(If not institution, give street and number)*: Mercy Medical Center
4b. City, Town, or Location of Death:
4c. County of Death:

Funeral Director

5. Social Security Number: none
6. Sex: 1 ☒ M 2 ☐ F
7. Age *(In yrs. last birthday)* Yrs.: If Under 1 Year Months: 0 Days: 0; If Under 24 Hrs. Hours: 1 Min.: 20
8. Date of Birth *(Month, Day, Year)*: 12/24/97
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3121 Marco Ave 2nd Fl.
10f. Zip Code: 21213
10g. Citizen of What Country: USA

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No *Specify:* AA
14. Race - American indien, Bleck, White, etc. *Specify:* Black
15. Decedent's Education *(Specify only highest grade completed)* Elementary/Secondery (0-12): 0 College (1-4or 5+): 0
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: none- infant
16b. Kind of Business/Industry: none
17. Fether's Name *(First, Middle, Last)*: Steven Hiram Newman JR
18. Mother's Name *(First, Middle, Maiden Sumame)*: Shenninta Ann Allison
19e. Informent's Name/Relationship *(Type, Print)*: Shenninta Ann Allison
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3121 Marco Avenue 2nd Floor Balto. MD 21213
20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremetion 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*:
Date:
20c. Location - City or Town, Stete:
21. Signeture of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death)
a. Extreme Prematurity
Due to (or es e consequenca of):
b. CHORIOAMNIONITIS

Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequenca of):
c.
Due to (or es a consequence of):
d.

Part ii. **Other significant conditions** contributing to death but not resulting in the underiying cause given in Part i.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Wes an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Wes case referred to medical examiner? 1 ☐ Yes 2 ☒ No
26. Place of Death *(Check only one)* Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*
27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigetion 6 ☐ Could not be determined
28a. Date of injury *(Month, Day Year)*:
28b. Time of injury: M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred:
28e. Pleca of injury - At home, farm, street, factory, office building, etc. *(Specify)*:
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29e. Certifier *(Check only one)*: 1 ☑ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end piece, and due to the cause(s) and manner stated.
29b. Signeture and title of certifier:
29c. License number: D20998
29d. Date signed *(Month, Day, Year)*: December 24, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 1998
Registrar's Signature: Julia Patterson-Reeves

DHMH 16 Rev 6/95

K.B

97-6423-510
CIP
FRANCES BUSCEMI

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41427

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
FRANCES BUSCEMI	NOVEMBER 7, 1997	4:10AM

4e. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
JOHNS HOPKINS GERIATRIC CENTER	BALTIMORE	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
216-05-4784	1☐ M 2☒ F	80 Yrs.			NOV.15,1916	Md.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	N/A	BALTIMORE	☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
2117 DENNISON ST.	21216	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed ☒ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes ☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
4		WAITRESS	FOOD SERVICE

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
JOSEPH BUSCEMI	UNKNOWN

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
SHARON CORWELL [CARETAKER]	2117 DENNISON ST. BALTIMORE, Md. 21216

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	SPRINGFIELD CEMETERY	11/14/97	SYKESVILLE, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
per vr ▶ PAIGE HAIGHT HERBERT	HAIGHT FUNERAL HOME P.O. BOX 195 SYKESVILLE, Md. 21784

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RESPIRATORY FAILURE/ARREST

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Chronic Obstructive Pulmonary Disease, VENTILATOR DEPENDENT

Due to (or as a consequence of):

c. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

FALL RIGHT HIP FRACTURE

SURGICAL FIXATION

SCHIZOPHRENIA

23b. Did tobacco use contribute to the cause of death? 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: ☒ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined	9/18/1997	UNKNOWN M	1☐ Yes 2☒ No	SUBJECT FELL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
NURSING HOME	CRAWFORD NURSING HOME

29a. Certifier (Check only one)

1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Dennis J. Chute M.D.	O.C.M.E.	DECEMBER 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DENNIS J. CHUTE M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 26 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Physician or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

97-6910-510
AM
KYRAH
BANKS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items:8,23 part I,27,28a-f per MEO G-758 4/2/98 reb

Certificate of Death

Reg. No. 97 41428

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Kyrah Banks	NOVEMBER 28, 1997	2:30 P

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
MARYLAND GENERAL HOSPITAL ER	BALTIMORE	Baltimore City

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
none	1☐ M 2☒ F	Yrs.	4		~~July 2~~, 1997	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore City	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1513 Mosher Street	21217	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Rican, etc.)	14. Race - Americen Indian, Black, White, etc.
1☒ Nevar Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Datas:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Educetion (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondery (0-12)	College (1-4or 5+)		
none 0	0	none - infant	none

17. Father's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Maiden Surname)
unknown	Ericka Ames

19a. Informant's Name/Raiationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Ericka Ames/mother	1411 Division Street, Baltimore, Maryland 21217

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☒ Removal from State 4☐ Donation 5☐ Other (Specify)			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ronald S. Wade, Director	State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart fellure. List only ona cause on eech line.

		Approximete Interval Between Onset and Death
Immediate Cause (Final diseese or condition resulting in death)	a. MALNUTRITION AND DEHYDRATION	
	Due to (or es e consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying ceuse given in Part I.

23b. **Did tobacco usa contributa to the cause of death?** 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of ceuse ot death?
1☑ Yes 2☐ No	1☑ Yes 2☐ No

25. Was case referred to medicel examiner?	26. Piece of Deeth (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending invastigation 6☒ Could not be determined	found 11/28/97	found 2:00 P M	1☐ Yes 2☒ No	Unknown
	28e. Piece of Injury - At home, ferm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)
	Unknown			Unknown

29a. Cartifiar (Check only one)
1☐ **Certifying Phyaician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and place, and dua to the ceuse(s) and manner stated.

29b. Signature and title of certifier	29c. Licansa number	29d. Data signed (Month, Day, Year)
Marquita Bonesteel	OCME	NOVEMBER 29, 1997

30. Name end eddess ot person who completed ceuse ot deeth (Item 23e) (Type, Print)
MARYANN B. KOHLER MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Dete filed (Month, Day, Year)	32. Registrar's Signeture
JAN 23 1998	Julia Davidson-Randall

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Department of Heelth end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

K.B

DHMH 16 Rev 6/95

Items: 9 thru 22 Per FH Per KB Film G-758 4-3-98RC

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Replacement

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41429

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day	Year	3. Time of Death
BABY GIRL DENNIS	12	2	97	1:56AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
The Johns Hopkins Hospital	Baltimore	—

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
NONE	1☐M 2☒F	Yrs.				6	12-2-97	MARYLAND

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD		BALTIMORE	1☐Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1007 N. WOLFE STREET	21205	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Yeer or Dates:	1☐Yes 2☒No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0	0	INFANT	INFANT

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
CRAIG FORMAN	CHERICE DENNIS

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
CHERICE DENNIS/ MOTHER	1007 N. WOLFE STREET, BALTIMORE, MD. 21205

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☒Other (Specify) DISPOSAL	JOHNS HOPKINS HOSPITAL	12/2/97	BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
PER DVR ▶ RAYMOND JOHNSON	600 N. WOLFE STREET, BALTIMORE, MD. 21285

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Respiratory Arrest	6 minutes
Due to (or as a consequence of):	b. PRETERM BIRTH	6 minutes
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Extreme Prematurity	6 minutes
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

NONE

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒Yes 2☐No	1☐Yes 2☒No

25. Was cese referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶ Adam J. Duhl MD	RGS-000	3/2/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
ADAM J. DUHL, MD JOHNS HOPKINS HOSPITAL

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JAN 22 1998	Julia Davidson Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

WRC
97-7258-510
WILLIAM
JONES Item: 7 Per Meo Film G-755 1-26-98RC

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 97 41430

Physician /Medical Examiner

1. Decedent's Nema *(First, Middle, Last)*: William Jones
2. Date of Death — Month: DECEMBER Dey: 16, Year: 1997
3. Time of Death: 8:37 PM.
4e. Facility Name *(If not institution, give street and number)*: 11 W. 20th. ST. APT#2E
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: unknown
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 62 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Dey, Year)*: June 24, 1935
9. Birthplece *(State or Foreign Country)*: unknown

Usuel Residence of Decedent

10e. Stete: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 11 W. 20th Street, Apt. 2E
10f. Zip Coda: 21218
10g. Citizen of Whst Country?: U.S.A.

11. Meritel Status: unknown — 1 [ ] Never Married 2 [ ] Merried 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? unknown — 1 [ ] Yes 2 [ ] No If Yes, Giva Yeer or Detes:
13. Wes Decedant of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) — 1 [ ] Yes 2 [X] No *Specify:*
14. Rece - American Indian, Bleck, White, etc. — *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): unknown; College (1-4or 5+): unknown
16a. Decedent's Usuel Occupetion *(Giva kind of work done during most of working life. DO NOT usa ratired)*: unknown
16b. Kind of Business/Industry: unknown
17. Fether's Name *(First, Middle, Last)*: unknown
18. Mother's Neme *(First, Middle, Meiden Sumame)*: unknown
19e. Informent's Name/Reletionship *(Type, Print)*: Arunene Hopkins/sister
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: unknown
20e. Mathod of Disposition — 1 [ ] Buriel 2 [ ] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [X] Othar *(Specify)* in state
20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*
Dete
20c. Location - City or Town, Stete
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name end Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part 1. Entar tha disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heert failure. List only one ceuse on eech line. — Approximate Interval Between Onsat and Death

Immediate Ceuse (Finel diseese or condition resulting in daath)
a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE
Due to (or es e consequence of):
Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet Initiated events resulting in death) Lest
b.
Dua to (or es e consaquenca of):
c.
Due to (or es e consequence of):
d.

Pert II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an eutopsy performed? PENDING 1 [ ] Yes 2 [ ] No
24b. Were eutopsy findings available prior to completion of cause of deeth? 1 [✓] Yes 2 [ ] No

25. Was case referrad to medical examiner? 1 [X] Yes 2 [ ] No
28. Placa of Deeth *(Check only one)* — Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other *(Specify)*
27. Manner of Death — 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Dey Yaar)*
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*
28f. Location *(Streat and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)* — 1 [ ] **Certifying Physician**: To tha best of my knowledga, daath occurred et tha tima, date and pleca, and due to tha causa(s) end menner as stated. 2 [X] **Medical Examiner**: On the basis of examinetion and/or investigation, in my opinion, daeth occurred et the time, dete and place, end due to the cause(s) end menner stated.

29b. Signeture end title of certifier
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: DECEMBER 17, 1997

30. Nama and eddress of parson who completed cause of deeth (Item 23e) (Type, Print): MARYLAND D. KOHOUT M2 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Deta filed *(Month, Day, Yaar)*: JAN 26 1998
32. Registrer's Signeture: Julia Faulkner Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 41431

Items:24a,29a per MD G-755 1/23/98 dh

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Anthony JACKSON

2. Date of Death Month / Day / Year: Dec 5th 1997

3. Time of Death: 10:45 AM

4a. Facility Name *(If not Institution, give street and number)*: Heartland Health Care

4b. City, Town, or Location of Death: Hyattsville

4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: 579-74-3994

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 41 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: January 4, 1956

9. Birthplace *(State or Foreign Country)*: D.C.

Usual Residance of Decedent

10a. State: Maryland

10b. County: Prince Georges

10c. City, Town or Location: Hyattsville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 6500 Riggs Road

10f. Zip Code: 20783

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indien, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondary (0-12): unknown; College (1-4or 5+): unknown

16a. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: House Keeper

16b. Kind of Business/Industry: Hotel

17. Father's Name *(First, Middle, Last)*: Walter Jackson

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Geraldine Jackson

19a. Informant's Neme/Reletionship *(Type, Print)*: Geraldine J. Evans/mother

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, State, Zip Code)*: unknown

20a. Method of Disposition: 1☐Burial 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☒Other *(Specify)* in state

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*

Dete

20c. Location - City or Town, Stete

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director — 12/12/97

22. Neme end Address of Feciilty: State Anatomy Board, 655 W. Baltimroe Street Baltimroe, Maryland 21201

Physician /Medical Examiner

23a. Pert1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such es cerdiac or raspiretory errest, shock, or heert feilura. List only one cause on eech line.

Approximete Interval Between Onset end Death

Immediete Ceuse (Final disease or condition resulting in death)

e. CARDIO RESPIRATORY FAILURE — 1 DAY

Due to (or es e consequence of):

AIDS

Sequentielly list conditions, if eny, leading to immediete ceuse. Enter Underlying Cause (Disease or Injury thet Initieted events resulting in death) Last

b.

Due to (or es e consequence of):

c. LYMPHOMA

Due to (or es e consequence of):

d.

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Wes en eutopsy performed? 1☐Yes 2☒No

24b. Were eutopsy findings eveilable prior to completion of ceuse of deeth? 1☐Yes 2☐No

25. Wes case referred to medicel examiner? 1☐Yes 2☒No

26. Plece of Deeth *(Check only one)*: Hospitel: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☒Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Deeth: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*: NA

28b. Time of Injury: NA M

28c. Injury at Work? 1☐Yes 2☒No

28d. Describe how injury occurred: NA

28e. Piece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*: NA

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*: NA

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) and menner as stated. 2☐**Medical Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner stated.

29b. Signature and title of certifier

29c. License number: D42019

29d. Dete signed *(Month, Dey, Year)*: DEC 5TH 1997

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Imran Chowdhury, MD. 7350 VAN DUSEN RD #220 Laurel, MD. 20707

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 23 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41432

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): William Roger Morral

2. Date of Death (Month, Day, Year): December 26 1997

3. Time of Death: 11:30 p.m.

4a. Facility Name (If not institution, give street and number): The Memorial Hospital at Easton

4b. City, Town, or Location of Death: Easton

4c. County of Death: Talbot

Funeral Director

5. Social Security Number: none

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday): Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours 2 / Min. 10

8. Date of Birth (Month, Day, Year): 12/26/97

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Caroline

10c. City, Town or Location: Denton

10d. Inside City Limits: 1 ☐ Yes 2 ☒ No

10e. Street and Number: 25424 Dodd Lane

10f. Zip Code: 21629

10g. Citizen of What Country?: US

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 | College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): none - infant

16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): Roger Lee Morral

18. Mother's Name (First, Middle, Maiden Surname): Nancy Lynn Bell

19a. Informant's Name/Relationship (Type, Print): Nancy Lynn Bell/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 25424 Dodd Lane, Denton, MD 21629

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place): State Anatomy Board

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Extreme Prematurity — 2 hrs.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or es e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one): Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Cathleen J. McGrath MD

29c. License number: D39740

29d. Date signed (Month, Day, Year): 1-3-98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Cathleen J McGrath 910 Market St Denton MD 21629

State Registrar

31. Date filed (Month, Day, Year): JAN 23 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

William Roger Morral

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

K.B

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41433

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Taylor Mills

2. Date of Death — Month: December Day: 27 Year: 1997

3. Time of Death: 7:00 am.

4a. Facility Name (If not institution, give street and number): Mercy Medical Center

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: none

6. Sex: 1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday) Yrs.: If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: 1 Min: 35

8. Date of Birth (Month, Day, Year): Dec 27 1997

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland 10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 4802 Hamilton Ave #30

10f. Zip Code: 21206

10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black.

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 0 College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): none - infant

16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): Charlie Earnest Mills

18. Mother's Name (First, Middle, Maiden Surname): Michelle Cunningham.

19a. Informant's Name/Relationship (Type, Print): Michelle Cunningham

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4802 Hamilton Ave #3C Baltimore 21206

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Anatomy Board

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade State Anatomy Board

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Extreme Prematurity

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one) — Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Neonatology

29c. License number: D48175

29d. Date signed (Month, Day, Year): 12/27/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Andres Rodriguez MD 301 St Paul Place, Baltimore

State Registrar

31. Date filed (Month, Day, Year): JAN 23 1998

32. Registrar's Signature: Julia Davidson-Randall

KB

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

97-4786-015
AM
UNK.97-184

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41434
Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: UNKNOWN 97-184
2. Date of Death Month Day Year: AUGUST 25, 1997
3. Time of Death: 0730 A
4a. Facility Name *(If not institution, give street and number)*: 1246 NORTHEAST RD.
4b. City, Town, or Location of Death:
4c. County of Death: CECIL

Funeral Director

5. Social Security Number: unknown
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: unknown Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: unknown
9. Birthplace *(State or Foreign Country)*: unknown

Usual Residence of Decedent

10a. State: unknown
10b. County: unknown
10c. City, Town or Location: unknown
10d. Inside City Limits: unknown 1 [ ] Yes 2 [ ] No
10e. Street and Number: unknown
10f. Zip Code: unknown
10g. Citizen of What Country?: unknown

11. Marital Status: unknown — 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever In U.S. Armed Forces? unknown — 1 [ ] Yes 2 [ ] No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): unknown — 1 [ ] Yes 2 [ ] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): unknown | College (1-4or 5+): unknown
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unknown
16b. Kind of Business/Industry: unknown

17. Father's Name *(First, Middle, Last)*: unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: unknown

19a. Informant's Name/Relationship *(Type, Print)*: unknown
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: unknown

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [X] Other *(Specify)* in state
20b. Place of Disposition *(Name of cemetery, crematory or other place)*:
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

DAB #30

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in death)
a. Gunshot Wounds of Head and Multiple
Due to (or as e consequence of):
b. Stab and Cutting Wounds

Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disease or Injury thet initieted events resulting in death) Last
Due to (or es a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings evelleble prior to completion of cause of deeth? 1 [X] Yes 2 [ ] No

25. Was case referred to medical exeminer? [X] Yes 2 [ ] No
26. Piece of Death *(Check only one)*: Hospitel: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other *(Specify)* FIELD

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Yeer)*: UNK
28b. Time of Injury: UNK M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Sharp Cut, stabbed, shot
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*: UNK
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: Found 1246 NorthEast RD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date end placa, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: OCME
29d. Dete signed *(Month, Day, Year)*: AUGUST 26, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 22 1998
32. Registrar's Signature:

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No: 97 41435

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DONALD EDWARD BROWN

2. Date of Death: Month: Dec Day: 30 Year: 1997

3. Time of Death: 1749

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 219-46-1477

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 50 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 21, 1947

9. Birthplace (State or Foreign Country): Maryland

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 1417 Kensington Drive

10f. Zip Code: 21742

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Pipe Maker

16b. Kind of Business/Industry: Pipe Organ Mfg.

17. Father's Name (First, Middle, Last): Charles Henry Brown

18. Mother's Name (First, Middle, Maiden Surname): Mary Edna Domer

19a. Informant's Name/Relationship (Type, Print): Peggy R. Smith

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 431, Falling Waters, W.Va. 25419

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematorium | Date: 12-31-97

20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service License: ▶ R. Noel Brady

22. Name and Address of Facility: Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, Md. 21740

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac arrest — instant

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b. Coronary artery disease

Due to (or as a consequence of):
c.

Due to (or es e consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end manner stated.

29b. Signature end title of certifier: ▶ MD

29c. License number: D30584

29d. Date signed (Month, Day, Year): 12/31/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Laurence Greenspoon, M.D. / 130 W. High St. / Hancock, MD. 21750

State Registrar

31. Date filed (Month, Day, Year): JAN 07 1998

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Brown, Donald

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41436

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Josephine Barth

2. Date of Death Month: December Day: 29 Year: 1997

3. Time of Death: 9:50 Am

4a. Facility Name *(If not institution, give street and number)*: Williamsport Nursing Home

4b. City, Town, or Location of Death: Williamsport

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 103-16-7424A

6. Sex: 1☐ M 2☒ F

7. Age *(If yrs. last birthday)*: 90 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct 8, 1907

9. Birthplace *(State or Foreign Country)*: Austria

Usual Residence of Decedent

10a. State: New Jersey

10b. County: Bergen

10c. City, Town or Location: Paramus

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 368 Midland Avenue

10f. Zip Code: 07652

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own home

17. Father's Name *(First, Middle, Last)*: Karl Gangl

18. Mother's Name *(First, Middle, Maiden Surname)*: Josephine Henschl

19a. Informant's Name/Relationship *(Type, Print)*: Cecile Barth Armor

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2636 Lakeside Drive, Erie, Penna.

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: George Washington Mem. Pk.

Date: 1/3/98

20c. Location - City or Town, State: Paramus, New Jersey

21. Signature of Funeral Service Licensee: Sharon Carmelle Cline

22. Name and Address of Facility: Stauffer Funeral Home 21702, 1621 Opossumtown Pike, Frederick, Maryland

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Pneumonia — 48 hours.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Senile Dementia.

Suspected Colonic Malignancy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☒ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of *my* knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: T E Howe. MD

29c. License number: D33700

29d. Date signed *(Month, Day, Year)*: December 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): TED E. HOWE 7542 OVERLOOK DR. BOONSBORO, MD 21713

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997

32. Registrar's Signature: Julia Davidson Cook

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41437

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: JAMES WALTER BRADEN

2. Date of Death Month: DECEMBER Day: 25 Year: 1997

3. Time of Death: 04:40pm

4e. Facility Name *(If not institution, give street and number)*: FORT WASHINGTON HOSPITAL

4b. City, Town, or Location of Death: FORT WASHINGTON

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: 220-39-1954

6. Sex: 1☒ M 2☐ F

7. Age *(In yrs. last birthday)*: 4 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: October 5, 1993

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10e. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Ijamsville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 2030 Fire Tower Lane

10f. Zip Code: 21754

10g. Citizen of What Country?: American

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0 | College (1-4or 5+):

16e. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: None - Child

16b. Kind of Business/Industry: None

17. Father's Name *(First, Middle, Last)*: David Neil Braden

18. Mother's Name *(First, Middle, Maiden Surname)*: Marjorie Arlene Foster

19e. Informant's Name/Relationship *(Type, Print)*: Diane Heinz - Grandmother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 3 Hattaras Court, Bordentown, New Jersey 08505

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Olivet Cemetery

Date: 1/2/98

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Olin L. Molesworth

22. Name and Address of Facility: Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. NECK INJURY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24e. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Date of Injury *(Month, Day, Year)*: 12-25-97

28b. Time of Injury: 03:15PM

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: PASSENGER OF AUTO REAR ENDED BY ANOTHER VEHICLE

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: STREET

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: RT 210 & BERRY RD, ACCOKEEK, MARYLAND

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Mario F. Golle Jr. MD

29c. License number: MD D-33954

29d. Date signed *(Month, Day, Year)*: DECEMBER 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MARIO F. GOLLE JR MD 3501 HOSPITAL DRIVE, CHEVERLY MARYLAND, 20785

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 31 1997

32. Registrar's Signature: Julia Davidson Rankin

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41438

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Allan Marcel Creed

2. Date of Death Month / Day / Year: December 24 1997

3. Time of Death: 2:20 AM

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 017-01-3539

6. Sex: 1 ☐ M 2 ☒ F

7. Age *(In yrs. last birthday)*: 89 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: April 15, 1908

9. Birthplace *(State or Foreign Country)*: Vermont

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1 ☒ Yes 2 ☐ No

10e. Street and Number: 257 Wyngate Drive

10f. Zip Code: 21701

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No — If Yes, give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ Yes 2 ☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): — College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Accountant

16b. Kind of Business/Industry: Public Utility

17. Father's Name *(First, Middle, Last)*: William R. CREED

18. Mother's Name *(First, Middle, Maiden Surname)*: Mary GUEVIN

19a. Informant's Name/Relationship *(Type, Print)*: Mary Ellen Rhoderick, Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8802 River Oaks Terrace, Frederick, MD 21704

20a. Method of Disposition: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Resthaven Mem. Gardens, Dec. 26, 1997

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ Allan H Ruby M00703

22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home, 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Chronic Obstructive Pulmonary Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death *(Check only one)*: Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other *(Specify)*

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: ▶ Allen J Gilson

29c. License number: D26516

29d. Date signed *(Month, Day, Year)*: DEC 24 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Allen J. Gilson MD 1475 Taney Ave Fred MD 21702

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997

32. Registrar's Signature: Julia Davidson Rudacille

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended #s 28c, 30; MHS, 1/4/98, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41439

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anthony L. Drees, Jr.

2. Data of Death — Month: December; Day: 27; Yaar: 1997

3. Tima of Death: 07:45 AM

4a. Facility Neme (If not institution, giva street and number): 2706 Finzel Road

4b. City, Town, or Location of Death: Frostburg

4c. County of Death: Allegany

Funeral Director

5. Social Security Numbar: 217-28-9386

6. Sax: 1 ☒ M 2 ☐ F

7. Aga (In yrs. last birthday): 66 Yrs.

If Under 1 Yaer: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Data of Birth (Month, Day, Year): 12-Mar-31

9. Birthplaca (State or Foraign Country): Maryland

Usual Rasidance of Dacedant

10a. Stata: Maryland

10b. County: Allegany

10c. City, Town or Location: Frostburg

10d. Insida City Limits: 1 ☐ Yas 2 ☒ No

10e. Street and Numbar: 2706 Finzel Road

10f. Zip Coda: 21532-

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1 ☐ Nevar Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Evar in U.S. Armed Forcas? 1 ☒ Yes 2 ☐ No. If Yas, Giva Yaar or Dates: 1955-1959

13. Was Dacedent of Hispenic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.): 1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highast grade compleatad)

Elementary/Secondary (0-12): 12

College (1-4or 5+): 0

18a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa ratirad): Bobbin Department

16b. Kind of Businass/Industry: Textile manufacturing

17. Fathar's Nama (First, Middla, Last): Anthony Drees, Sr.

18. Mother's Name (First, Middla, Maiden Surnama): Dessie Rosenberger

19a. Informant's Name/Ralationship (Type, Print): Shirley Drees — Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Coda): 2706 Finzel Road Frostburg Maryland 21532-

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cramation 3 ☐ Ramovel from Stata 4 ☐ Donation 5 ☐ Othar (Specify)

20b. Place of Disposition (Nama of cematary, cramatory or othar place): Finzel Cemetery

Data: 30-Dec-97

20c. Location - City or Town, Stata: Finzel, Maryland

21. Signatura of Funaral Service Licensee: John R. Durst

22. Nama and Addrass of Facility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

Physician /Medical Examiner

23a. Part I. Entar tha diseasa, or complications that caused tha daath. Do not entar tha mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on each lina.

Approximate Intarval Batwaen Onsat and Death

Immediate Ceusa (Final disease or condition resulting in daath)

a. Carcinoma — 2 years

Dua to (or as a consaquance of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Underlying Cause (Disaasa or injury that initiated avants resulting in daath) Last

b.

Dua to (or as a consaquanca of):

c.

Due to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No

24b. Were autopsy findings availeble prior to completion of causa of death? 1 ☐ Yas 2 ☐ No

25. Was casa refarrad to madical examinar? 1 ☐ Yas 2 ☐ No

28. Placa of Daath (Check only ona)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Homa 5 ☐ Rasidance 8 ☐ Othar (Specify)

27. Mannar of Daath: 1 ☐ Naturel 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be datarmined

28a. Data of Injury (Month, Dey Year)

28b. Tima of Injury M

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

28f. Location (Straat and Number or Rural Route Number, City or Town, Stata)

29a. Certifiar (Check only one): 1 ☑ **Certifying Phyeician**: To the best of my knowledge, deeth occurred at tha tima, data end plece, and dua to tha ceusa(s) and mannar as stated. 2 ☐ **Medical Examiner**: On tha basis of examination and/or investigation, in my opinion, daath occurred at tha tima, date and place, and due to the cause(s) and manner stated.

29b. Signatura end title of certifiar: John Lusby PA

29c. License number: D3607606

29d. Data signed (Month, Day, Year): December 31, 1997

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): Vikramadiya Poonal, M.D., ~~955 Frederick Street, Cumberland, Maryland 21532~~ 120 National Highway, LaVale, Maryland 21502

State Registrar

31. Data filed (Month, Day, Year): JAN 06 1998

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

5

MHS

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41440

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gordon Lee DRONEBURG
2. Date of Death (Month, Day, Year): December 28, 1997
3. Time of Death: 8:40 A.M.
4a. Facility Name (If not institution, give street and number): College View Center
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-10-3599
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Aug. 9, 1903
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 700 Toll House Avenue
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired): Power Press Operator
16b. Kind of Business/Industry: Manufacturing

17. Father's Name (First, Middle, Last): Baxter DRONEBURG
18. Mother's Neme (First, Middle, Maiden Surname): Neva KREGILO

19a. Informant's Name/Relationship (Type, Print): Donald L. Droneburg, Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1138 Little Magothy View, Annapolis, MD 21401

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cematary, cramatory or othar place): Resthaven Memorial Gardens, Dec. 30, 1997
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ Allan H Ruby M00703
22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
a. Septicemia generalized sepsis — 1 wk
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Due to (or es a consequence of):
d. H/o schizophrenia, dementia,

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only ona): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Naturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spacify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Phyaician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ S. Mohiuddin
29c. License number: D39458
29d. Date signed (Month, Day, Yaar): December 31, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Sabiha Mohiuddin, M.D., 801 Toll House Ave., Building B, Suite 1, Frederick, MD 21701

State Registrar

31. Dete filed (Month, Day, Year): DEC 31 1997
32. Registrer's Signature: ▶ Julie Strickler Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41441

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: MARGARET WILHELMINA FLEMING

2. Date of Death Month / Day / Year: DECEMBER 31, 1997

3. Time of Death: 7:34 AM

4a. Facility Neme *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-10-3739

6. Sex: 1☐ M 2☒ F

7. Age *(in yrs. last birthday)*: 85 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Day, Year)*: May 24, 1912

9. Birthplece *(State or Foreign Country)*: Maryland

Usuel Residence of Decedent

10a. Stete: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: ☒ Yes 2☐ No

10e. Street and Number: 6012 Fair Oaks Drive

10f. Zip Code: 21703

10g. Citizen of What Country?: U.S.A.

11. Maritel Status: 1☐ Navar Married 2☐ Married 3☒ Widowad 4☐ Divorced

12. Wes Decedent Evar in U.S. Armed Forces? 1☐ Yes ☒ No If Yes, Give Year or Dates:

13. Wes Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes ☒ No *Specify:*

14. Race - American Indian, Bleck, White, etc. *Specify:* White

15. Decadent's Education *(Specify only highast grade completed)*: Elementery/Secondery (0-12): 8 | College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Giva kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Neme *(First, Middle, Last)*: John William FALK

18. Mother's Neme *(First, Middle, Maiden Surname)*: Elizabeth Florence DAVIS

19a. Informent's Name/Relationship *(Type, Print)*: Mrs. Donna Smith, Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6012 Fair Oaks Drive, Frederick, Maryland 21703

20a. Method of Disposition: ☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cametery, crematory or other place)*: Mount Olivet Cemetery, January 3, 1998

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funerel Service Licensee: ▶ Richard E. Hrad MO0255

22. Nama end Address of Facility: Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the deeth. Do not enter the *mode* of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in deeth)
a. Aspiration Pneumonia — Due to (or as a consequence of): — 1 day

Sequentielly list conditions, if eny, leading to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
b. — Due to (or as a consequence of):
c. — Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

CHF
COPD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes ☒ No 3☐ Probably 4☐ Unknown

24a. Wes en autopsy performed? 1☐ Yes ☒ No

24b. Wara autopsy findings aveilable prior to completion of cause of deeth? 1☐ Yes ☒ No

25. Was case referred to medical exeminer? 1☐ Yes ☒ No

26. Piece of Deeth *(Check only one)*: Hospitel: ☒ 1 Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Menner of Deeth: ☒ 1 Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: ☒ 1 **Certifying Phyaician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end *m*enner es steted. 2☐ **Medical Examiner:** On the basis of examinetion end/or investigetion, in my opinion, death occurred et the time, dete end placa, and due to the cause(s) end *m*anner steted.

29b. Signetura end titia of certifiar: ▶ Allen J. Gilson

29c. Licanse number: D 26516

29d. Data signed *(Month, Day, Year)*: Dec 31 1997

30. Name end edress of person who completed cause of deeth (Item 23e) (Type, Print): Allen J. Gilson MD 1475 TANEY AVE FRED MD 21702

State Registrar

31. Date filed *(Month, Dey, Year)*: DEC 31 1997

32. Registrer's Signeture: ▶ Julia Strickland Rudolph

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41442

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Phillip Lee Freeland

2. Date of Death Month Day Year: December 25, 1997

3. Time of Death: 06:24 a.m.

4a. Facility Name *(If not institution, give street and number)*: FREDERICK MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: FREDERICK

4c. County of Death: NA

Funeral Director

5. Social Security Number: 219-66-3735

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 41 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Data of Birth *(Month, Day, Year)*: MAR 4 56

9. Birthplace *(State or Foreign Country)*: MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: NA

10c. City, Town or Location: FREDERICK

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 238 PHEBUS AVE.

10f. Zip Code: 21701

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Datas:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decadent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 TH | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: LABORER

16b. Kind of Business/Industry: APPLE PLANT

17. Father's Name *(First, Middle, Last)*: PHILLIP LEE BROWN

18. Mother's Name *(First, Middle, Maiden Surname)*: AGNUS FREELAND

19a. Informant's Name/Relationship *(Type, Print)*: AGNUS FREELAND (MOTHER)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 238 PHEBUS AVE. FREDERICK MD. 21701

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donetion 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory, or other place)*: ST. JOHNS CEM. 29

Date: DEC 97

20c. Location - City or Town, State: FREDERICK

21. Signature of Funeral Service Licensee: ▶ Gary L. Rollins

22. Name and Address of Facility: GARY L. ROLLINS FUNERAL HOME 21701
110 WESR ALL SAINTS ST. FREDERICK MD.

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar the moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximata Interval Between Onset and Death

Immediete Cause (Final disaasa or condition resulting in death): a. Dilated Cardiomyopathy — 1 yr

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events rasulting in death) Last:

b. Due to (or as a consequence of):

c. Dua to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availabla prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Piece of Deeth *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Homa 5 [ ] Residenca 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D30721

29d. Data signed *(Month, Day, Year)*: 12/29/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DeHaven N. Lowe MD 310 W. 5th St Frederick MD 21701

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997

32. Registrar's Signature: ▶ [signature] Linda Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41443

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Naomi Grace Fulmer
2. Date of Death (Month, Day, Year): December 25, 1997
3. Time of Death: 2:30PM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 212-14-7147
6. Sex: 1☐M 2☒F
7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Feb. 13, 1923
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 327 South Market Street
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondary (0-12): 6 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Councilor
16b. Kind of Business/Industry: Dormitory/School

17. Father's Name (First, Middle, Last): John Wilbur FULMER
18. Mother's Name (First, Middle, Maiden Surname): Mary SHANK

19a. Informant's Name/Relationship (Type, Print): Mrs. Annabelle Cannon, Sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 327 South Market Street, Frederick, Md. 21701

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from Stete 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mount Olivet Cemetery, Dec. 29, 1997
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: ▶ Richard E. Graf M00255
22. Name and Address of Facility: Keeney and Basford P.A. Funeral Home 106 East Church Street, Frederick, Md. 21701

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Finel disease or condition resulting in death): a. Chronic Obstructive Pulmonary Dis — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last:
b. Due to (or as a consequenca of):
c. Due to (or es a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☒Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No
24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☒No

25. Was case referred to medical examiner? 1☐Yes 2☒No
26. Piece of Death (Check only one): Hospitel: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)
27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, end due to the ceuse(s) end manner as stated. 2☐**Medicat Examtner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated.

29b. Signature and title of certifier: ▶ Allen J. Gilson
29c. License number: D 26516
29d. Date signed (Month, Day, Year): Dec 26 1997

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print): Allen J. Gilson MD 1475 TANEY AVE FREDERICK MD 21702

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997
32. Registrar's Signature: Edwin Davidson Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41444

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): SHERI LYNN GEMMELL
2. Date of Death Month Day Year: December 23, 1997
3. Time of Death: 6:25 A.M.
4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 217-04-5545
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 27 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 30, 1970
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Mt. Airy
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 913 Horizon Rd.
10f. Zip Code: 21771
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Educetion (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Budget Assistant
16b. Kind of Business/Industry: Naval Medical Research

17. Fether's Name (First, Middle, Last): Boyce Wallace
18. Mother's Name (First, Middle, Maiden Surname): Sharon Wallace

19a. Informant's Neme/Reletionship (Type, Print): Paul Gemmel / Husband
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 913 Horizon Rd./ Mt. Airy, Md. 21771

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): Pine Grove Cemetery
Date: 12-27-97
20c. Location - City or Town, State: Mt. Airy, Maryland

21. Signature of Funeral Service Licensee: Ryan M. Burgen
22. Nama and Address of Facility: Stauffer Funeral Home, 8 E. Ridgeville Blvd./ Mt. Airy, Md. 21771

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cerdiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disaase or condition resulting in deeth)
a. Pulmonary Embolism / Cardiac Arrest
Due to (or as a consequence of):
b. Post Partum Day #2
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Hodgkins Lymphoma
Dee to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.
2 days Status Post Vaginal Delivery of live Female

23b. Did tobacco use contribute to ths causs of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigetion 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and mannar stated.
29b. Signature and title of certifier: MD
29c. License number: AD25307
29d. Date signed (Month, Day, Year): Dec 23 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CRAIG DICKMAN MD 15215 Shady Grove Rd. Rockville, MD 20850

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41445

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Richard L. Gladhill

2. Date of Death Month / Day / Year: December 28, 1997

3. Time of Death: 7:20 P.M.

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 214-34-0392

6. Sex: 1☐ M 2☐ F

7. Age *(In yrs. last birthday)*: 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: July 18, 1937

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☐ Yes 2☐ No

10e. Street and Number: 6809 Sunny Brook Drive

10f. Zip Code: 21702

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Maintenance Supervisor

16b. Kind of Business/Industry: ESSROC

17. Father's Name *(First, Middle, Last)*: Luther O. Gladhill, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Elizabeth L. Snoots

19a. Informant's Name/Relationship *(Type, Print)*: Gerry Gladhill - wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6809 Sunny Brook Drive, Frederick, Maryland 21702

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetary, cremetory or other place)*: Resthaven Memorial Gardens

Date: 12-31-97

20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Sharon Camille Cline

22. Name and Address of Facility: Stauffer Funeral Home, 1621 Opossumtown Pike, Frederick, Maryland 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure — 7 d

Due to (or as a consequence of):

b. Extensive Mesothelioma — 3 4-5

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

pericardial Mesothelioma

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residance 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D14c 2c

29d. Date signed *(Month, Day, Year)*: Dec 28, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): DG Mauser 541 W Seventh St Frederick MD 21701

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 30 1997

32. Registrar's Signature: Julia Strickler Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41446

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Jane HULL
2. Date of Death Month / Day / Year: December 26 1997
3. Time of Death: 5:20 pm
4a. Facility Name *(If not institution, give street and number)*: Stella Maris Nursing Home
4b. City, Town, or Location of Death: Timonium
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 214-74-1781
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 102 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Nov. 27, 1895
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore
10c. City, Town or Location: Towson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 8110 Pleasant Plains Road
10f. Zip Code: 21286
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker
16b. Kind of Business/Industry: Own Home
17. Father's Name *(First, Middle, Last)*: Frank GILBERT
18. Mother's Name *(First, Middle, Maiden Surname)*: Marietta HAHN
19a. Informant's Name/Relationship *(Type, Print)*: Mary Angela Hull, Daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 8110 Pleasant Plains Road, Towson, MD 21286
20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mount Olivet Cemetery, Dec. 30, 1997
20c. Location - City or Town, State: Frederick, Maryland
21. Signature of Funeral Service Licensee: Allan H Ruby M00703
22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home, 106 East Church Street, Frederick, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death): e. DEMENTIA — Approximate Interval Between Onset and Death: Five Years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: ASCVD

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☒ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier:
29c. License number: D25686
29d. Date signed *(Month, Day, Year)*: 12-30-97
30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Ebrahim Ipakchi, M.D. 2300 Dulaney Valley Rd Timonium, Md. 21093

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 05 1998
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: MARY HULL

AMENDED #206 FCHD AES

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41447

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ronald Lee Kline Sr.

2. Date of Death (Month, Day, Year): December 24, 1997

3. Time of Death: 9:30 PM

4a. Facility Name (If not institution, give street and number): 3429 Brethren Church Road

4b. City, Town, or Location of Death: Myersville

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-60-4969

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 44 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 20, 1953

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Myersville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3429 Brethren Church Road

10f. Zip Code: 21773

10g. Citizen of What Country? USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Carpenter

16b. Kind of Business/Industry: Building Construction

17. Father's Name (First, Middle, Last): Charles Clayton Kline, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Helen Elizabeth Cline

19a. Informant's Name/Relationship (Type, Print): Deborah A. Kline

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3429 Brethren Church Road, Myersville, MD 21773

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Ch Of Breth Cemt

Date: ~~12-19-97~~ 12-29-97

20c. Location - City or Town, State: Harmony, Maryland

21. Signature of Funeral Service Licensee: Lacy L Ricketts

22. Name and Address of Facility: Ricketts Funeral Home, 504 Main Street, Myersville, MD 21773

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Respiratory Failure — 2 days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. lymphangitic tumor — 10d

Due to (or as a consequence of):

c. esophageal carcinoma — 3 mo

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of certifier: [signature]

29c. License number: D14202

29d. Date signed (Month, Day, Year): Dec 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): D G Rausch MD 501 W 7th St Frederick MD 21701

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amend #20b, 1/5/98, BMW, Montg. Co.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41448

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Lazur
2. Date of Death (Month, Dey, Yeer): December 30, 1997
3. Time of Death: 15:45
4a. Facility Neme (If not institution, give street end number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 043-16-0436
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. lest birthdey): 81 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Yeer): Oct. 21, 1916
9. Birthplece (Stete or Foreign Country): Connecticut

Usuel Residence of Decedent

10a. Stete: Ohio
10b. County: Montgomery
10c. City, Town or Location: Dayton
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 2290 Millwood Road
10f. Zip Code: 45440
10g. Citizen of Whet Country?: United States

11. Meritel Status: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Dates:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Reca - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12) / College (1-4or 5+): 5+
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Electrical Engineer
16b. Kind of Business/Industry: Civil Service

17. Fether's Neme (First, Middle, Last): Balzek Lazur
18. Mother's Neme (First, Middle, Meiden Surneme): Branistawa Lewiski

19a. Informant's Neme/Reletionship (Type, Print): Edward G. Lazur/Son
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 14540 Pettit Way, Potomac, Maryland 20854

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removel from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetery, crematory or other place): Montgomery Crematorium, Inc.
Date: January 3, ~~1997~~ 1998
20c. Location - City or Town, Stete: Bethesda, Maryland

21. Signeture of Funerel Service Licensee: M01126
22. Neme end Address of Feciity: Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805

Physician /Medical Examiner

23a. Pert I. Enter the disease, or complications thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Interval Between Onset end Deeth
Immediete Ceuse (Finel diseese or condition resulting in death) e.	SEPTICEMIA	7 DAYS
Due to (or es e consequence of):	CONGESTIVE HEART FAILURE	7 DAYS
Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Disease or Injury thet initieted events resulting in deeth) Lest b. Due to (or es e consequence of):	PLEURAL EFFUSION	6MONTHS
c. Due to (or es e consequence of):	LYMPHOMA	12 MONTHS
d.		

Pert II. **Other significent conditione** contributing to death but not resulting in the underlying cause given in Pert I.

23b. **Did tobecco use contribute to the cause of death?** 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings eveileble prior to completion of ceuse of deeth? 1 [ ] Yes 2 [X] No

25. Wes cese referred to medicel exeminer? 1 [ ] Yes 2 [X] No
26. Piece of Deeth (Check only one): Hospitel: 1 [X] Inpetient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Menner of Death: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigetion 6 [ ] Could not be determined
28a. Dete of Injury (Month, Dey Yeer)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end place, end due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the beeis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end due to the ceuse(s) and manner steted.

29b. Signeture end title of certifier: /M.D.
29c. License number: D-40201
29d. Dete signed (Month, Dey, Yeer): DECEMBER 30th, 1997

30. Neme and eddress of person who completed cause of deeth (Item 23e) (Type, Print): FARZAD ASSAR, M.D. 19251 MONTG. VILLAGE AVE. F-24/GAITHERSB. MD 20879

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 05 1998
32. Registrer's Signeture:

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41449

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Sandra KAY Long
2. Date of Death: Month December Day 24 Year 1997
3. Time of Death: 4:10 AM
4a. Facility Name (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL
4b. City, Town, or Location of Death: FREDERICK
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 219-52-1280
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 48 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 27, 1949
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: FREDERICK
10c. City, Town or Location: THURMONT
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 12005 LUCEY ROAD
10f. Zip Code: 21788
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: SHOE FACTORY

17. Father's Name (First, Middle, Last): ALONZO RUFUS BARKMAN
18. Mother's Name (First, Middle, Maiden Surname): CATHERINE MARIE BAXTER

19a. Informant's Name/Relationship (Type, Print): GRAYSON D. LONG (HUSBAND)
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12005 LUCEY ROAD THURMONT, MD. 21788

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): BLUE RIDGE CEMETERY
Date: 12/29/97
20c. Location - City or Town, State: THURMONT, MD.

21. Signature of Funeral Service Licensee: Robert E. Dailey Jr.
22. Name and Address of Facility: ROBERT .E DAILEY & SON FUNERAL HOMES, P.A. 615 E. MAIN ST. THURMONT, MD. 21788

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Metastatic small cell lung Cancer	16 months
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
Due to (or as a consequence of):		
	c.	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☑ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one): Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: D 48184
29d. Date signed (Month, Day, Year): 12/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Elhamy Eskander 501 West 7th Street Frederick Md 21701

State Registrar

31. Date filed (Month, Day, Year): DEC 31 1997
32. Registrar's Signature: Julia Davidson Rudolph

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41450

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): GLENN ROBERT LARE

2. Date of Death (Month, Day, Year): Dec. 21, 1997

3. Time of Death: 00:50

4a. Facility Name (If not institution, give street end number): WASHINGTON COUNTY HOSPITAL

4b. City, Town, or Location of Death: HAGERSTOWN

4c. County of Death: WASHINGTON

Funeral Director

5. Social Security Number: 217-28-2177

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 66 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): FEB. 9, 1931

9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: FREDERICK

10c. City, Town or Location: ROCKY RIDGE

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 13102 A OLD FREDERICK RD.

10f. Zip Code: 21778

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): FARMER

16b. Kind of Business/Industry: FARMING

17. Father's Name (First, Middle, Last): HARVEY McCELLAN LARE

18. Mother's Name (First, Middle, Maiden Surname): AMY RUTH HARRIS

19a. Informant's Name/Relationship (Type, Print): AMY R. LARE (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13102 A OLD FREDERICK RD., ROCKY RIDGE, MD 21778

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): CREAGERSTOWN CEMETERY

Date: 12/23/97

20c. Location - City or Town, State: CREAGERSTOWN, MD

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 E. MAIN ST., THURMONT, MD 21788

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cardiac Arrest — two min

Due to (or as a consequence of):
b. Acute Myocardial Infarction — two hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Coronary Artery Disease — yrs

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Multiple Sclerosis Chronic Obstruction Pulmonary Disease

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D18019

29d. Date signed (Month, Day, Year): Dec 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr Datta 334 Mill St. Hagerstown, Md

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997

32. Registrar's Signature:

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

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Glen Lare

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41451

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rebecca C. Manges
2. Date of Death (Month, Day, Year): Dec 30, 1997
3. Time of Death: 7:05 am
4a. Facility Name (If not institution, give street and number): Memorial Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 210-10-7577
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Sep 23, 1908
9. Birthplace (State or Foreign Country): PA

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 907 Michigan Avenue
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retired
16b. Kind of Business/Industry: First National Bank

17. Father's Name (First, Middle, Last): Albert Staniforth
18. Mother's Name (First, Middle, Maiden Surname): Alice William

19a. Informant's Name/Relationship (Type, Print): Becky Stanevich-granddaughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 4 Box 238AA Grafton WV 26354

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, cremetory or other place): Hillcrest Memorial Park
Date: 01/03
20c. Location - City or Town, State: Cumberland MD

21. Signature of Funeral Service Licensee: ▶ James F Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland MD 21502

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Congestive Heart Failure	3 years
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	Coronary Artery Disease	3 years
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dehydration

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☒ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Thomas Evan Chappell
29c. License number: D35135
29d. Date signed (Month, Day, Year): 1/5/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Thomas Evan Chappell MD 912 Seton Dr Cumberland MD

31. Date filed (Month, Day, Year): JAN 07 1998
32. Registrar's Signature: ▶ [illegible]

State Registrar

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
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Division of Vital Records, P.O. Box 68760,

MANGES, REBECCA S 220 10 7577

10

YMS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41452

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
Leo McClelan Miller	Dec. 31, 1997	2:15 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Frederick Healthcare Center	Frederick	Frederick

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year Months / Days	If Under 24 Hrs. Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
220-18-3038	1☒M 2☐F	72 Yrs.			Nov.6, 1925	Md.

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Frederick	Frederick	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5030 Witmer Lane	21703	U.S.A.

11. Maritel Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Amarican Indian, Black, White, etc.
1☐Never Marriad 2☒Married 3☐Widowed 4☐Divorced	1☒Yes 2☐No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elamantary/Secondary (0-12)	Collega (1-4or 5+)		
8		truck driver	transportation

17. Fether's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surneme)
Bradley Claude Miller	Lillian Pauline Taylor

19a. Informent's Name/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Marcelene L. Miller (Wife)	5030 Witmer Lane, Frederick, Md. 21703

20a. Mathod of Disposition	20b. Place of Disposition (Neme of cemetery, cremetory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Lutheran Cemetery	1/3	Middletown, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ [signature]	Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failura. List only one cause on each lina.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final disaasa or condition resulting in death)	e. Cerebrovascular Disease	years
	Due to (or as e consequence of):	
Sequentiellly list conditions, if any, leading to immadiete causa. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last	b. Hypertension	years
	Due to (or es a consequence of):	
	c. Hyperlipidemia	years
	Due to (or as a consaquence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

Parkinsons Disease

Dementia

23b. Did tobacco use contribute to the cause of death?	24a. Was an autopsy performad?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☐No 3☒Probably 4☐Unknown	1☐Yes 2☒No	1☐Yes 2☐No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA	Other: 4☒Nursing Homa 5☐Residence 8☐Other (Specify)

27. Manner of Deeth	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how Injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigetion 6☐Could not be determined		M	1☐Yes 2☐No	
	28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)			28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete)

29a. Certifier (Check only one)
1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and menner es steted.
2☐**Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner steted.

29b. Signetura and titla of certifier	29c. Licanse number	29d. Date signed (Month, Dey, Yeer)
▶ [signature]	D47556	1/5/98

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)
WILLIAM H. JOHNSON 187 THOMAS JOHNSON DRIVE FREDERICK MD 21702

State Registrar

31. Dete filed (Month, Dey, Yeer)	32. Registrar's Signature
JAN 05 1998	[signature]

DHMH 16 Rev 6/95

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41453

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DELLA CLASON MOLLER

2. Date of Death Month/Day/Year: DECEMBER 31, 1997

3. Time of Death: 0355

4a. Facility Name (If not institution, give street and number): HOMEWOOD RETIREMENT CENTER

4b. City, Town, or Location of Death: FREDERICK

4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 140-30-3159

6. Sex: 1☐ M 2☒ F (X)

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 7-26-1908

9. Birthplace (State or Foreign Country): NEW JERSEY

Usual Residence of Decedent

10a. State: MD

10b. County: FREDERICK

10c. City, Town or Location: FREDERICK

10d. Inside City Limits: 1☒ Yes (X) 2☐ No

10e. Street and Number: 31 WEST PATRICK STREET

10f. Zip Code: 21701

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed (X) 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No (X) If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No (X) Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4 or 5+): 4 YEARS

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): SCHOOL TEACHER

16b. Kind of Business/Industry: TEACHING/EDUCATION

17. Father's Name (First, Middle, Last): JOSEPH SPERLING

18. Mother's Name (First, Middle, Maiden Surname): LUCRETIA VANRYPER

19a. Informant's Name/Relationship (Type, Print): HENRY G. MOLLER (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1207 OAKWOOD DRIVE FREDERICK, MD. 21701

20a. Method of Disposition: 1☒ Burial (X) 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): MOUNT OLIVET CEMETERY | Date: 1/3/98

20c. Location - City or Town, State: FREDERICK, MD.

21. Signature of Funeral Service Licensee: Robert E. Dailey

22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 N. MARKET ST. FREDERICK, MD. 21701

Physician /Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Hypertensive Cardiovascular Disease — years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown (X)

24a. Was an autopsy performed? 1☐ Yes 2☒ No (X)

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No (X)

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☒ Nursing Home (X) 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural (X) 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (X) 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C. E. Cline III MD

29c. License number: D16428

29d. Date signed (Month, Day, Year): JANUARY 2, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C. E. CLINE, III, MD. 300 WEST 9TH ST. FREDERICK, MD. 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1998

32. Registrar's Signature: Julia Strickland Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

97-7474-021

HUNTER
McMANUS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41454

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month / Day / Year	3. Time of Death
HUNTER	CLAYTON	McMANUS	DECEMBER 25, 1997	2:08P.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FREDERICK MEMORIAL HOSPITAL	FREDERICK	FREDERICK

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-45-4990	1☒ M 2☐ F	2 Yrs.			JULY 5, 1995	MARYLAND

Usual Residence of Decedent

10e. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
MARYLAND	FREDERICK	EMMITSBURG	1☒Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of Whet Country?
9 ADAMS AVE.	21727	USA

11. Maritel Status	12. Wes Decedent Ever In U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.)	14. Rece - Americen Indien, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
N/A	N/A	N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Meiden Surname)
CHRISTOPHER CLAYTON McMANUS	ANNA MARY WASTLER

19e. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
CHRISTOPHER C. McMANUS (FATHER)	9 ADAMS AVE., EMMITSBURG, MD 21727

20a. Method of Disposition	20b. Placa of Disposition (Neme of cemetery, cremetory or other place)	Dete	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	GRACEHAM CEMETERY	12/29/97	GRACEHAM, MARYLAND

21. Signature of Funeral Service Licensee ▶ [signature]

22. Name and Address of Facility
ROBERT E. DAILEY & SON FUNERAL HOMES, P.A.
615 EAST MAIN STREET, THURMONT, MD 21788

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiretory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximete Interval Between Onset and Death
Immediate Ceuse (Finel disease or condition resulting in deeth)	a. Drowning	
	Due to (or as a consequenca of):	
Sequentially list conditions, if any, leading to immediete cause. Enter Underlying Ceuse (Disease or injury thet initieted events resulting in death) Last	b.	
	Due to (or as a consequenca of):	
	c.	
	Due to (or as a consequenca of):	
	d.	

Part II. Othar significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco uaa contributs to the causs of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed?	24b. Were autopsy findings eveilable prior to completion of ceuse of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medicel examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Deeth	28e. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	12/25/97	11:50 A M	1☐ Yes 2☒ No	Subject fell into pond.

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
House	10834 PutmanRd. Thurmont, Fred. Co.

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as steted.
2☒ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and piece, end due to the cause(s) end manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Donald G. Wright MD	O.C.M.E.	DECEMBER 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrer's Signature
JAN 08 1998	▶ [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other trauma event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41455

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Daniel Louis Montgomery

2. Data of Daath — Month: December; Day: 26; Year: 1997

3. Tima of Death: 7:30 P.M.

4a. Facility Nama *(If not institution, give street and number)*: 12177 Overlook Drive

4b. City, Town, or Location of Death: Monrovia

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 218-30-7174

6. Sex: 1 [X] M 2 [ ] F

7. Aga *(In yrs. last birthday)*: 60 Yrs.

If Under 1 Yaer — Months: ; Deys:

If Undar 24 Hrs. — Hours: ; Min.:

8. Date of Birth *(Month, Day, Year)*: Feb. 26, 1937

9. Birthplaca *(State or Foreign Country)*: Maryland

Usual Residance of Dacedent

10a. Stata: Maryland

10b. County: Frederick

10c. City, Town or Location: Monrovia

10d. Insida City Limits: 1 [ ] Yas 2 [X] No

10e. Street and Number: 12177 Overlook Drive

10f. Zip Coda: 21770

10g. Citizan of What Country?: American

11. Marital Status: 1 [ ] Navar Married 2 [X] Married 3 [ ] Widowad 4 [ ] Divorcad

12. Wes Dacedent Ever in U.S. Armed Forcas? 1 [X] Yas 2 [ ] No — If Yas, Giva Yaar or Datas: Vietnam

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 1 [ ] Yas 2 [X] No *Specify:*

14. Rece - Amarican Indian, Black, Whita, atc. *Specify:* AfroAmerican

15. Decedant's Education *(Specify only highest grade completed)*

Elamantary/Secondary (0-12):

Collaga (1-4or 5+): 8

16a. Decedant's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Engineer

16b. Kind of Businass/Industry: Electrical

17. Fathar's Nama *(First, Middle, Last)*: Richard C. Montgomery

18. Mothar'e Name *(First, Middle, Maiden Surname)*: Edna Distance

19a. Informant's Name/Ralationship *(Type, Print)*: Nelson R. Montgomery - Son

19b. Mailing Addrass *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 301 Old Airport Road, Douglasville, Pennsylvania 19518

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Ramoval from Stata 4 [ ] Donation 5 [ ] Othar *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metropolitan Crematorium

Data: 12/27/97

20c. Location - City or Town, Stata: Alexandria, Virginia

21. Signatura of Funaral Sarvice Licansaa: Robert L. Williams

22. Nama and Addrass of Facility: Olin L. Molesworth, P.A., Funeral Home, 26401 Ridge Road, Damascus, Maryland 20872-0117

Physician /Medical Examiner

23a. Part I. Enter tha disaasa, or complicetions that caused tha daath. Do not anter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failura. List only ona causa on aach lina.

Approximata Intarval Batwaen Onsat and Death

Immediate Causa (Final disaasa or condition rasulting in daath)

a. Amyotrophic Lateral Sclerosis — Approximata Intarval: ?

Dua to (or as a consaquanca of):

Saquantially list conditions, if any, laading to immadiata causa. Enter Undarlying Causa (Disaasa or injury that initiatad avants resulting in daath) Last

b. Dua to (or as a consaquanca of):

c. Dua to (or as a consaquanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa given in Part I.

23b. Did tobacco usa contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yas 2 [ ] No

25. Was case rafarrad to medical examinar? 1 [ ] Yes 2 [X] No

26. Placa of Daath *(Check only one)*: Hospital: 1 [ ] Inpatiant 2 [ ] ER/Outpatient 3 [ ] DOA — Othar: 4 [ ] Nursing Hama 5 [X] Residance 6 [ ] Othar *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicida 4 [ ] Homicida 5 [ ] Pending Investigation 6 [ ] Could not be determinad

28a. Data of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yas 2 [ ] No

28d. Describe how Injury occurred

28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifiar *(Check only one)*: 1 [X] **Certifying Phyaician:** To tha best of my knowladga, daath occurrad at tha time, date and place, and dua to tha causa(s) and mannar as statad. 2 [ ] **Medical Examiner:** On tha basis of axamination and/or investigation, in my opinion, death occurrad at the time, date and place, and dua to tha causa(s) and mannar steted.

29b. Signature and title of certifiar: George I. Smith VPMA M.D.

29c. Licansa number: D 10587

29d. Data signed *(Month, Day, Year)*: 12/27/97

30. Nama and addrass of parson who completed cause of death (Itam 23a) (Type, Print): GEORGE I. SMITH JR MD VPMA — FREDERICK MEMORIAL HOSP. 400 W. 7TH ST. FREDERICK, MD. 21701

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997

32. Registrar's Signatura: Julia Strickler Rankin

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41456

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward Leroy PEASE
2. Date of Death (Month, Day, Year): December 23, 1997
3. Time of Death: 10:00 A.M.
4a. Facility Name (If not institution, give street and number): Homewood Retirement Center
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 156-07-8502
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 80 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 25, 1917
9. Birthplace (State or Foreign Country): Pennsylvania

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 109 West 14th Street
10f. Zip Code: 21701
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates: 1942 to 1945
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Director of Transportation
16b. Kind of Business/Industry: U. S. Government

17. Father's Name (First, Middle, Last): George Ralph Pease
18. Mother's Name (First, Middle, Maiden Surname): Sarah Dorothy Morgan

19a. Informant's Name/Relationship (Type, Print): Judith L. Prosseda/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 109 West 14th Street, Frederick, Md. 21701

20a. Method of Disposition: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Olivet Cemetery
Date: Dec. 27, 1997
20c. Location - City or Town, State: Frederick, Md.

21. Signature of Funeral Service Licensee: Richard C. C. Basford M00021
22. Name and Address of Facility: Keeney & Basford Funeral Home, 106 East Church Street, Frederick, Md. 21701

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cancer of Prostate — 5 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
parkinson's Disease

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one): Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 ☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Casper E. Cline III MD
29c. License number: D16428
29d. Date signed (Month, Day, Year): 12/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Casper E. Cline, III, M.D., 300 West Ninth Street, Frederick, Md. 21701

State Registrar

31. Date filed (Month, Day, Year): DEC 2 9 1997
32. Registrar's Signature: Judi Davidson Rudolph

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41457

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Ona Odell Parks
2. Date of Death Month / Day / Year: Dec 31 1997
3. Time of Death: 4:55 am
4a. Facility Name *(If not institution, give street and number)*: SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 229-36-8089
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 64 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: March 7 1933
9. Birthplace *(State or Foreign Country)*: Virginia

Usual Residence of Decedent

10a. State: MD
10b. County: Montgomery
10c. City, Town or Location: Dickerson
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 21800 Dickerson Road
10f. Zip Code: 20842
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 6 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: homemaker
16b. Kind of Business/Industry: homemaker

17. Father's Name *(First, Middle, Last)*: George Cliffton Parks
18. Mother's Name *(First, Middle, Maiden Surname)*: Minne Delle Ross

19a. Informant's Name/Relationship *(Type, Print)*: Albert F. Parks husband
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 21800 Dickerson Rd Dickerson, MD 20842

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Monocacy
Date: 1/2/98
20c. Location - City or Town, State: Beallsville, MD

21. Signature of Funeral Service Licensee: ▶ Willa C Hilton
22. Name and Address of Facility: Hilton Funeral Home Barnesville, MD 20838

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Congestive Heart Failure — Hours

Due to (or as a consequence of):
b. Acute Myocardial Infarction — Hours

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day, Year)*: 12/31/97
28b. Time of Injury: M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Brett Gamma
29c. License number: D 51980
29d. Date signed *(Month, Day, Year)*: December 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Brett Gamma Shadt Grove Medical Ctr Rockville, MD 20850

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 2 1998
32. Registrar's Signature: ▶ Christian Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41458

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Camille Maggie Robbins

2. Date of Death (Month, Day, Year): December 31, 1997

3. Time of Death: 2:20 AM

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 212-38-7687

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 90 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 10 1907

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Washington

10c. City, Town or Location: Knoxville

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 1316 Rohrersville Rd

10f. Zip Code: 21758

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): School Teacher

16b. Kind of Business/Industry: Brunswick Elem. School

17. Father's Name (First, Middle, Last): Peter T. Harris

18. Mother's Name (First, Middle, Maiden Surname): Cicely A. Anderson

19a. Informant's Name/Relationship (Type, Print): Russell Lee Robbins

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10220-204 Hickory Ridge Rd Columbia MD 21044

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Moriah Cemetery | Date: 1/3/98

20c. Location - City or Town, State: Garretts Mill, MD

21. Signature of Funeral Service Licensee: Barbara A. Williams, Owner

22. Name and Address of Facility: John T. Williams Funeral Home 100 Petersville Rd Brunswick MD 21716

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Cancer of (L) Ovary — + weeks

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Carcinomatosis Secondary to Ovarian Ca — + weeks

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: D.O. Clapsis M.D.

29c. License number: DO 7186

29d. Date signed (Month, Day, Year): 12/31/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 814 to 11 House Ave, Frederick, Md. 21701

State Registrar

31. Date filed (Month, Day, Year): JAN 05 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Amended #12, DBS, 1/12/98, Allegany County

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41459

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Harvey (N.M.N.) Skidmore, Sr.

2. Date of Death — Month: December; Day: 23; Year: 1997

3. Time of Death: 1105 AM

4a. Facility Name *(If not institution, give street and number)*: 11511 Blan Avon Road, S.W.

4b. City, Town, or Location of Death: Midlothian

4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 213-12-9999

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 77 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 18-Sep-20

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Allegany

10c. City, Town or Location: Midlothian

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street and Number: 11511 Blan Avon Road, S.W.

10f. Zip Code: 21543-

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: ~~1956-1959~~ 1942-1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Owner/Operator

16b. Kind of Business/Industry: Auto wrecker/repair service

17. Father's Name *(First, Middle, Last)*: Howard Skidmore, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Elvira Davis

19a. Informant's Name/Relationship *(Type, Print)*: Isabelle Skidmore Wife

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 11511 Blan Avon Road, S.W. Midlothian Maryland 21543-

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Frostburg Memorial Park

Date: 27-Dec-97

20c. Location - City or Town, State: Frostburg, Maryland

21. Signature of Funeral Service Licensee: John R. Durst

22. Name and Address of Facility: Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Malignant Lymphoma, Non-Hodgkins, Stage 4B — 9 mo

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Coronary Atherosclerosis

Prostate Cancer in Remission

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☒Residence 8☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas F. Hogan MD

29c. License number: West Va 13054

29d. Date signed *(Month, Day, Year)*: Jan 2, 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print): Thomas Hogan, M.D., Byrd Health Center, Dept. of Medicine, P.O.Box 9162, Morgantown, WV 26506

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 0 8 1998

32. Registrar's Signature

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41460

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Clayton L. Smith Sr.
2. Date of Death Month Day Year: December 31, 1997
3. Time of Death: 11:35 PM
4a. Facility Name *(If not institution, give street and number)*: Memorial Hospital
4b. City, Town, or Location of Death: Cumberland
4c. County of Death: Allegany

Funeral Director

5. Social Security Number: 705-10-7983
6. Sex: 1☐ M 2☐ F
7. Age *(In yrs. last birthday)*: 92 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: Sep 24, 1905
9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD
10b. County: Allegany
10c. City, Town or Location: Cumberland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 614 W. Industrial Blvd.
10f. Zip Code: 21502
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Ret. Shop Mechanic
16b. Kind of Business/Industry: Western MD Railroad

17. Father's Name *(First, Middle, Last)*: Jesse A. Smith
18. Mother's Name *(First, Middle, Maiden Surname)*: Annie H. (Divelbiss)

19a. Informant's Neme/Relationship *(Type, Print)*: Sharon Parkinson-daughter
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 614 W. Industrial Blvd. Cumberland MD 21502

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sunset Memorial Park — Date: 01/04
20c. Location - City or Town, Stete: Cumberland MD

21. Signature of Funeral Service Licensee: ▶ Nicholas J. Scarpelli
22. Name and Address of Facility: Scarpelli Funeral Home, P.A. Cumberland MD 21502

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complicetions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one ceuse on eech line.

		Approximate Interval Between Onset and Death
Immediete Ceuse (Final disease or condition resulting in death)	a. COLON CANCER	1 year
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last	b.	
	Due to (or es a consequence of):	
	c.	
	Due to (or as e consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings evalleble prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residenca 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signeture and title of certifier: ▶ J. Vik Poonai Dr
29c. License number: D 36766
29d. Date signed *(Month, Day, Year)*: January 6, 1998

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): Dr. Vik Poonai 922 National Hwy., LaVale, MD 21502

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1998
32. Registrar's Signature: Jabi Boucher-Ambrose

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

CLAYTON SMITH 705-10-7983

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41461

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUTH Frances STRAWSBURG

2. Date of Death (Month, Day, Year): DECEMBER 30, 1997

3. Time of Death: 11:15 AM

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 212-24-5828

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 81 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 27, 1916

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Thurmont

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 13407 Jimtown Road

10f. Zip Code: 21788

10g. Citizen of What Country?: U. S. A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 7

College (1-4 or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: own home

17. Father's Name (First, Middle, Last): Charles William Moser

18. Mother's Name (First, Middle, Maiden Surname): Bessie Flohr

19a. Informant's Name/Relationship (Type, Print): James Strawsburg - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 804 Cromwell Drive, Frederick, Maryland 21701

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Oak Hill Cemetery

Date: 1-3-1998

20c. Location - City or Town, State: Legore, Maryland

21. Signature of Funeral Service Licensee: Ryan M. Berger

22. Name and Address of Facility: Stauffer Funeral Home, 1621 Opossumtown Pike, Frederick, Md. 21702

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction — 5 min

Due to (or as a consequence of):

b. Severe COPD — 10-15 yrs.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Steroid Dependent Asthma — 50 yrs.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Atrial fibrillation

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one)

Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA

Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John A. Grimm M/D

29c. License number: D21944

29d. Date signed (Month, Day, Year): 12/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James S. Grimm M/D 300 W 9th St Frederick, Md 21701

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): JAN 02 1998

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41462

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): AnnaLee Schaden
2. Date of Death (Month, Day, Year): December 26, 1997
3. Time of Death: 8:30 A.M.
4a. Facility Name (If not institution, give street and number): 615 Fairview Avenue
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 219-14-9607
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 75 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Jan. 23, 1922
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 615 Fairview Avenue
10f. Zip Code: 21701
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Carol Lee Etchison
18. Mother's Name (First, Middle, Maiden Surname): Emma Taylor

19a. Informant's Name/Relationship (Type, Print): Dr. Harold E. Schaden/Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 615 Fairview Avenue, Frederick, Md. 21701

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory
Date: Dec. 27, 1997
20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Robert C. Basford M00021
22. Name and Address of Facility: Keeney & Basford Funeral Home, 106 East Church Street, Frederick, Md. 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Coronary Artery Disease — SUDDEN DEATH
Due to (or as a consequence of):
b. Hypertension — 10 years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
hypercholesterolemia
cancer of breast

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: A. Austin Pearre Jr.
29c. License number: D09689
29d. Date signed (Month, Day, Year): December 26, 1997
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): A. Austin Pearre, Jr, MD, 300 West Ninth Street, Frederick, Maryland 21701

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997
32. Registrar's Signature: Julia Davidson Rudolph

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RKD

97-7472-021

KENNETH SEARS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 41463

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Daath Month Day Year	3. Tima of Death
KENNETH ERMIL SEARS	DECEMBER 25, 1997	2:15P.M.

4a Facility Nama (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
FREDERICK CITY WATERSHED	FREDERICK	FREDERICK

Funeral Director

5. Social Security Number	6. Sax	7. Age (In yrs. last birthday)	If Under 1 Year Months	If Under 1 Year Days	If Under 24 Hrs. Hours	If Under 24 Hrs. Min.	8. Data of Birth (Month, Day, Year)	9. Birthplace (State or Foraign Country)
220-58-5445	1☒M 2☐F	44 Yrs.					July 20, 1953	Washington, D.C.

Usual Rasidance of Dacedant

10a. Stata	10b. County	10c. City, Town or Location	10d. Insida City Limits
Maryland	Frederick	Frederick	1☒Yes 2☐No

10e. Street and Number	10f. Zip Coda	10g. Citizan of What Country?
804-C Stratford Drive	21701	United States

11. Marital Status	12. Was Dacedant Evar in U.S. Armed Forcas?	13. Was Dacedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, atc.)	14. Race - American Indian, Black, Whita, atc.
1☐Naver Marriad 2☒Married 3☐Widowed 4☐Divorced	1☒Yas 2☐No If Yas, Give Year or Datas: 1972-1975	1☐Yas 2☒No Specify:	Specify: white

15. Decedent's Education (Specify only highast grade completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired)	16b. Kind of Business/Industry
Elamantary/Secondary (0-12)	Collega (1-4or 5+)		
12		Gradall Operator	Frederick City Highway Department

17. Fathar's Nama (First, Middla, Last)	18. Mothar's Nama (First, Middla, Maidan Surnama)
Horace Ermil Sears	Margaret Knott

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda)
Dianne Abrecht Sears / wife	804-C Stratford Drive, Frederick, MD 21701

20a. Mathod of Disposition	20b. Place of Disposition (Nama of camatary, crematory or othar placa)	Data	20c. Location - City or Town, Stata
1☒Burial 2☐Cramation 3☐Ramoval from State 4☐Donation 5☐Othar (Specify)	ResthavenMemorialGardens	12/29/97	Frederick, Maryland

21. Signature of Funaral Sarvice Licansaa	22. Name and Addrass of Facility
▶ Paul P. B. MacKay	Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complications that caused the daath. Do not antar tha moda of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona causa on aach lina.

Approximata Interval Between Onsat and Death

Immediate Causa (Final disaasa or condition resulting in daath)

a. Contact gunshot Wound to Head

Due to (or as a consaquanca of):

Sequentially list conditions, if any, laading to immadiata causa. Enter Undarlying Ceuse (Diseese or Injury that initiated evants resulting in death) Last

b.

Dua to (or as a consaquanca of):

c.

Dua to (or as a consaquanca of):

d.

Part II. **Other signiffcant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Wara autopsy findings availabla prior to completion of cause of daath?
1☒Yes 2☐No	1☒Yas 2☐No

25. Was casa raferrad to medical examinar?	26. Placa of Death (Check only ona)					
1☒Yas 2☐No	Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA	Othar: 4☐Nursing Homa 5☐Rasidance 6☒Other (Specify) SCENE				

27. Mannar of Death	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Describa how injury occurrad
1☐Naturel 2☐Accidant 3☒Suicida 4☐Homicida 5☐Pending invastigation 6☐Could not be determined	Found 12/25/97	11:27 AM	1☐Yas 2☒No	Subject shot self

28a. Placa of Injury - At home, farm, straat, factory, office building, atc. (Specify) watershed

28f. Location (Streat and Number or Rural Route Number, City or Town, State) Frederick City Watershed in Frederick County, Maryland

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Cartifier (Check only one) 1☐ **Certifying Physicfan:** To the best of my knowledge, daath occurred at the time, date and piace, and dua to tha cause(s) and mannar as stated. 2☒ **Medical Examfner:** On the basis of axamination and/or invastigation, in my opinion, daath occurred at the time, date and piace, and due to the cause(s) and mannar statad.

29b. Signature and titla of certifier	29c. Licanse number	29d. Date signed (Month, Day, Year)
▶ Theodore A. Kiger MD	O.C.M.E.	DECEMBER 26, 1997

30. Nama and addrass of person who complatad causa of daath (Item 23a) (Type, Print)

THEODORE KIGER 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filad (Month, Day, Year)	32. Registrar's Signature
DEC 30 1997	

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41464

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Rose Marie Tohol

2. Date of Death Month Day Year: December 31, 1997

3. Time of Death: 5:00 A.M.

4a. Facility Name *(If not institution, give street and number)*: 6743 Brace Court

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 298-24-8091

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 71 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Oct. 29, 1926

9. Birthplace *(State or Foreign Country)*: Ohio

Usual Residance of Decadant

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Insida City Limits: 1☒ Yas 2☐ No

10e. Street and Number: 6743 Brace Court

10f. Zip Coda: 21703

10g. Citizan of What Country?: United States

11. Marital Status: 1☐ Navar Marriad 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedant Evar in U.S. Armed Forces? 1☐ Yas 2☒ No If Yas, Giva Yaar or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.): 1☐ Yas 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedant's Education *(Specify only highast grada completed)*: Elamentary/Secondary (0-12): 12 / Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working lifa. DO NOT usa retired)*: Insurance Verification Clerk

16b. Kind of Businass/Industry: Frederick Surgery Center

17. Fathar's Name *(First, Middla, Last)*: Joseph Kernik

18. Mothar's Nama *(First, Middla, Maidan Surnama)*: Millie Merzel

19a. Informant's Name/Ralationship *(Type, Print)*: Jolynn Kernik, daughter

19b. Mailing Addrass *(Streat and Number or Rural Routa Number, City or Town, Stata, Zip Coda)*: 6743 Brace Court Frederick, Maryland 21703

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Place of Disposition *(Nama of cematary, crematory or othar place)*: Powhatan Cemetery

Data: 1/3/98

20c. Location - City or Town, State: Powhatan Point, Ohio

21. Signatura of Funaral Sarvica Licansaa ▶ [signature]

22. Nama and Addrass of Facility: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To Be Completed by Funeral Director

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not antar the moda of dying, such as cardiac or raspiratory arrast, shock, or heart failura. List only one cause on each line.

Approximata Intarval Batwaen Onsat and Death: 1 D

Immediata Causa (Final disease or condition rasulting in death)
a. Heart attack

Due to (or as a consequance of):
b. Family History of Heart Dx

Sequantially list conditions, if any, leading to immadiata cause. Entar Undarlying Causa (Disaasa or Injury that initiatad avants rasulting in daath) Last

Dua to (or as a consequanca of):
c. Episode of Emesis prior to death

Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yas 2☑ No

24b. Ware autopsy findings available prior to completion of causa of death? 1☐ Yas 2☐ No

25. Was casa rafarrad to medical examiner? 1☐ Yas 2☑ No

26. Place of Death *(Check only ona)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Othar: 4☐ Nursing Homa 5☑ Rasidance 6☐ Othar *(Specify)*

27. Mannar of Daath: 1☑ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarmined

28a. Date of Injury *(Month, Day Year)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Describe how injury occurred

28e. Placa of Injury - At homa, farm, straat, factory, offica building, atc. *(Specify)*

28f. Location *(Straat and Number or Rural Routa Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1☑ **Certifying Physician:** To tha best of my knowledga, death occurred at tha tima, data and placa, and dua to tha causa(s) and manner as stated. 2☐ **Medical Examiner:** On tha basis of examination and/or investigation, in my opinion, death occurred at tha tima, data and placa, and dua to tha causa(s) and manner stated.

29b. Signature and title of certifier ▶ [signature] MD

29c. Licansa number: D31384

29d. Data signed *(Month, Day, Year)*: 12/31/97

30. Name and addrass of parson who completed causa of death (Item 23a) (Type, Print): Dr. Jerry Stonemetz M.D. 7680 Stewart Hill, Adamstown, Md 21710 (Stonemetz)

State Registrar

31. Data filed *(Month, Day, Year)*: DEC 31 1997

32. Registrar's Signatura ▶ [signature]

DHMH 16 Rev 6/95

97-7478-021
CMK
CHRISTINA R. WILSON

Items:23a part I,27 per MEO G-755 1/28/98 dh

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41465
Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Christina Renee Wilson
2. Date of Death Month / Day / Year: DECEMBER 25, 1997
3. Time of Death: 2030PM
4a. Facility Name *(If not institution, give street and number)*: 6 NORTH MARYLAND AVENUE #6
4b. City, Town, or Location of Death: BRUNSWICK
4c. County of Death: FREDERICK COUNTY

Funeral Director

5. Social Security Number: 212-19-6173
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: 25 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: April 11, 1972
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Brunswick
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 6 North Maryland Ave., Apt 6
10f. Zip Code: 21716
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elamantary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT usa ratired)*: self
16b. Kind of Business/Industry: homemaker

17. Fathar's Name *(First, Middle, Last)*: Michael Alan Wiles
18. Mothar's Nama *(First, Middle, Maiden Surname)*: Bridget Lane Quesenberry

19a. Informant's Name/Relationship *(Type, Print)*: Jeffrey Wilson, Husband
19b. Malling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 6 North Maryland Ave., Apt 6, Brunswick, MD 21716

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Olivet Cemetery | Date: 12/29/97
20c. Location - City or Town, State: Frederick, Maryland

21. Signature of Funeral Service Licensee: Ryan M. Berger
22. Name and Address of Facility: Stauffer Funeral Homes, PA
1621 Opossumtown Pike, Frederick, MD 21702

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RIGHT VENTRICLE DYSPLASIA
Dua to (or as a consequanca of):
b.
Sequentially list conditions, if any, leading to immediata cause. Entar Underlying Cause (Disease or Injury that initiated evants resulting in death) Last
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☒ Yes 2☐ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicida 5☐ Panding investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Tima of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Routa Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To tha best of my knowledge, death occurred at the time, date and placa, and due to tha causa(s) and manner as stated. 2☒ **Medical Examinar**: On tha basis of examination and/or investigation, in my opinion, death occurred at tha time, date and placa, and due to the cauae(s) and manner stated.

29b. Signature and title of certifier: Theodore M. Kung
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: DECEMBER 26, 1997

30. Name and address of person who completed causa of death (Item 23a) (Type, Print): THEODORE M. Kung, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 27 1997
32. Registrar's Signature: Julie Hudson Rodgers

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41466

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Leona C. Williams

2. Date of Death Month Day Year: December 27, 1997

3. Time of Death: 2212

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 216-80-8123

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 80 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 17, 1917

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Monrovia

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 12009 Fingerboard Road

10f. Zip Code: 21770

10g. Citizen of What Country?: American

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 8 — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own home

17. Father's Name *(First, Middle, Last)*: George W. Gillis

18. Mother's Name *(First, Middle, Maiden Surname)*: Maude R. Mullinix

19a. Informant's Name/Relationship *(Type, Print)*: Dorothy A. Springer - Daughter

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 28411 Ridge Road, Mount Airy, Maryland 21771

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Mt. Lebanon Cemetery — Date: 12/31/97

20c. Location - City or Town, State: Damascus, Maryland

21. Signature of Funeral Service Licensee: Olin L. Molesworth

22. Name and Address of Facility: Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872-0117

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Cerebrovascular accident, Suspected	Sudden.
Due to (or as a consequence of): b.	Chronic renal failure	3 years.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death *(Check only one)*: Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☑ DOA — Other: 4☐ Nursing Home 5☑ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)* — 28b. Time of Injury — M — 28c. Injury at Work? 1☐ Yes 2☐ No — 28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)* — 28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: John Lodmell MD.

29c. License number: D05809

29d. Date signed *(Month, Day, Year)*: 12/28/97.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOHN G. LODMELL MD 2901 OLNEY RD. OLNEY MD 20832

State Registrar

31. Date filed *(Month, Day, Year)*: DEC 29 1997

32. Registrar's Signature: Julia Davidson Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97 41467

Amened #1, E.T. — FOR STATE REGISTRAR — Wchd, 12-15-97

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Mollie L. Yohn

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mollie L. ~~Ayres~~ Yohn					2. DATE OF DEATH (Month, Day, Year): DECEMBER 13 1997	3. TIME OF DEATH: 1:10 P M
4. SOCIAL SECURITY NUMBER: 229-07-4096	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 93 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 8-2-04	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): MANOKIN MANOR			9b. CITY, TOWN OR LOCATION OF DEATH: PRINCESS ANNE			9c. COUNTY OF DEATH: SOMERSET

RESIDENCE OF DECEDENT

10a. STATE: Virginia	10b. COUNTY: Accomack	10c. CITY, TOWN OR LOCATION: Sanford	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: Saxis Road	10f. ZIP CODE: 23426	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO (X) IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO (X) Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Domestic

17. FATHER'S NAME (First, Middle, Last): William Shaw	18. MOTHER'S NAME (First, Middle, Maiden Surname): Susan Smith
19a. INFORMANT'S NAME (Type/Print): Mrs. Howard Ayres	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 Downings Street Easton, MD

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Downings Cemetery	DATE: 12-16	20c. LOCATION — City or Town, State: Oak Hall, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James N. Fox	22. NAME AND ADDRESS OF FACILITY: Fox Funeral Home, Box 278-Temperanceville, VA 23442		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Heart Disease	20 years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerosis	30 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Diabetes Mellitus	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Organic Brain syndrome
Congestive Heart Failure

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: 24670	29d. DATE SIGNED (Month, Day, Year): 12/13/97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Ma. L. M. Evangelista 105 Pine Bluff Rd #4 Salisbury, MD 21801		
31. DATE FILED (Month, Day, Year): DEC 15 1997	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

3

DHMH-18 Rev 1/89

Amended Line 31 AES, FCHD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41468

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): JOHN ELMER YOUNG
2. Date of Death (Month, Day, Year): December 25, 1997
3. Time of Death: 2:50 PM
4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital
4b. City, Town, or Location of Death: Frederick
4c. County of Death: Frederick
5. Social Security Number: 217-18-7020
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 73 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): March 31, 1924
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10e. State: Maryland
10b. County: Frederick
10c. City, Town or Location: Frederick
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 324 East Third Street
10f. Zip Code: 21701
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postmaster
16b. Kind of Business/Industry: U.S. Post Office
17. Father's Name (First, Middle, Last): John G. Young
18. Mother's Name (First, Middle, Maiden Surname): Pearl Routzahn
19a. Informant's Name/Relationship (Type, Print): M. Catherine Young/Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 324 East Third Street, Frederick, Maryland 21701
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Resthaven Memorial Gardens
Date: 12/29
20c. Location - City or Town, State: Frederick, Maryland
21. Signature of Funeral Service Licensee: Robert E. Dailey Jr.
22. Name and Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 201 NORTH MARKET ST., FREDERICK, MD 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death)
a. Pneumonia
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Kidney Cancer

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: James A. Frizzell, MD
29c. License number: D16637
29d. Date signed (Month, Day, Year): 12/26/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): James A. Frizzell, MD, 915 Toll House Ave #201, Frederick

State Registrar

31. Date filed (Month, Day, Year): DEC 30 1997
32. Registrar's Signature: Julia Dawkins Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41469

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frederick Bernard Zimmerman

2. Date of Death (Month, Day, Year): December 23, 1997

3. Time of Death: 7:45 a.m.

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 578-05-4645

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 89 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Jun 24, 1908

9. Birthplace (State or Foreign Country): Pennsylvania

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Darnestown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 14200 Seneca Road

10f. Zip Code: 20874

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Cabinet Maker

16b. Kind of Business/Industry: Carpentry/Construction

17. Father's Name (First, Middle, Last): Frank ZIMMERAMAN

18. Mother's Name (First, Middle, Maiden Surname): Ruth UNKNOWN

19a. Informant's Name/Relationship (Type, Print): Bruce Zimmerman/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7321-A McKaig Road, Frederick, Maryland 21701

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory Dec

Date: 25,1997

20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Keith Lynn Robertson M00706

22. Name and Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Pneumonia	3 days
Due to (or as a consequence of): b.	Dehydration	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	Hyponatremia	3 days
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 3☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D47556

29d. Date signed (Month, Day, Year): 12/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): WILLIAM H. JOHNSON 187 THOMAS JOHNSON DRIVE FREDERICK MD 21702

State Registrar

31. Date filed (Month, Day, Year): DEC 29 1997

32. Registrar's Signature: Julie Davidson Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41470

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: MARY KATHERINE WALKER ZIMMERMAN

2. Date of Death Month Dey Year: DECEMBER 30, 1997

3. Time of Death: 12:09 PM

4a. Facility Name *(If not institution, give street and number)*: Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 213-05-7997

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 81 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Aug 29, 1916

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Frederick

10c. City, Town or Location: Frederick

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 104 Mercer Court, #15-7

10f. Zip Code: 21701

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Raca - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementery/Secondery (0-12) | College (1-4or 5+): 2

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name *(First, Middle, Last)*: George Edward WALKER Sr

18. Mother's Name *(First, Middle, Maiden Surname)*: Emma May HOUCK

19a. Informent's Neme/Reletionship *(Type, Print)*: Richard E. Zimmerman, Jr/Son

19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 104 Mercer Court #15-7, Frederick, Maryland 21701

20a. Method of Disposition: 1☒ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Mount Olivet Cemetery | Dete: Jan 3,1998

20c. Location - City or Town, Stete: Frederick, Maryland

21. Signature of Funeral Service Licensee: Kathlyn Roberson MO0706

22. Name end Address of Facility: Keeney & Basford P.A. Funeral Home 106 East Church St, Frederick, Maryland 21701

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heert failure. List only one cause on each line.

Approximete Interval Between Onset end Deeth

Immediate Cause (Finel diseese or condition resulting in deeth): e. Hepatoma — Approximate Interval: 6months

Due to (or as e consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest

b. Due to (or es e consequenca of):

c. Due to (or es e consequenca of):

d.

Part II. **Other signiftcant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes en eutopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

26. Piece of Deeth *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Yeer)* | 28b. Time of Injury M | 28c. Injury at Work? 1☐ Yes 2☐ No | 28d. Describe how injury occurred

28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. *(Specify)* | 28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, dete end pleca, end due to the ceuse(s) end menner es steted. 2☐ **Medical Exemtner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end menner stated.

29b. Signeture end title of certifier: Carrie E. Ching M.D.

29c. License number: D14428

29d. Date signed *(Month, Day, Year)*: 1/2/98

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print): 300 W. 9th St Frederick, Md. 21701

State Registrar

31. Dete filed *(Month, Day, Year)*: JAN 05 1998

32. Registrer's Signature

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41471

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DONALD W BOWERS SR.

2. Date of Death Month Day Year: DECEMBER 12,1997

3. Time of Death: 07:55 A.M.

4a. Facility Name *(If not institution, give street and number)*: THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death: NONE

Funeral Director

5. Social Security Number: 217-30-5513

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 64 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: JAN. 9,1933

9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MD

10b. County: WASHINGTON

10c. City, Town or Location: WILLIAMSPORT

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 20 N. ARTIZAN STREET

10f. Zip Code: 21795

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No. If Yes, Give Year or Dates: 4/53 TO 3/55

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* WHITE

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: MECHANIC

16b. Kind of Business/Industry: CERTAIN-TEED

17. Father's Name *(First, Middle, Last)*: FOSTER E. BOWERS

18. Mother's Name *(First, Middle, Maiden Surname)*: SARAH HOOVER

19a. Informant's Name/Relationship *(Type, Print)*: JOAN S. BOWERS

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 108 FAIRFAX XIRCLE, MARTINSBURG, WV 25401

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: ROSEDALE CEMETERY

Date: 12/15

20c. Location - City or Town, State: MARTINSBURG, WV.

21. Signature of Funeral Service Licensee: Charles M. Brown

22. Name and Address of Facility: BROWN FUNERAL HOME 327 W. KING STREET P.O. BOX 821, MARTINSBURG, WV 25402

Physician /Medical Examiner

23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. LINE SEPSIS	1 DAY
Due to (or as a consequence of):	b. PNEUMONIA	7 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a consequence of): c. ABDOMINAL AORTIC ANEURYSM REPAIR	25 DAYS
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: RES-000

29d. Date signed *(Month, Day, Year)*: December 12, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Iain Jenttsia, MD 600 North Wolfe St., Baltimore, MD 21287

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 27 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

16

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41472

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: BABY "A" BOY BATSON

2. Date of Death: Month DEC, Day 09, Year 1997

3. Time of Death: 1:30 A.M.

4a. Facility Name *(If not institution, give street and number)*: HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD

Funeral Director

5. Social Security Number: none

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: Yrs.

If Under 1 Year: Months, Days

If Under 24 Hrs.: Hours, Min. 20

8. Date of Birth *(Month, Day, Year)*: December 9, 1998

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 5740 Flag Flower Place

10f. Zip Code: 21045

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0; College (1-4or 5+): 0

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: none - infant

16b. Kind of Business/Industry: none

17. Father's Name *(First, Middle, Last)*: Jacob Maynard

18. Mother's Name *(First, Middle, Maiden Surname)*: Rebecca Batson

19a. Informant's Name/Relationship *(Type, Print)*: Rebecca Batson - mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5740 Flag Flower Place, Columbia, Maryland 21045

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other *(Specify)* in state

20b. Place of Disposition *(Name of cemetery, crematory or other place)*:

Date:

20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. EXTREME PREMATURITY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. PRE-TERM LABOR

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

NO PRENATAL CARE

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day Year)*:

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred:

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*:

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*:

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Swati M. Saraiya.

29c. License number: D30511

29d. Date signed *(Month, Day, Year)*: Dec 09, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Swati M. Saraiya, MD 11085 Little Patuxent Parkway Columbia MD 21044

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 1998

32. Registrar's Signature: Julia Gordon-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 8,10e Per MEO Film G-755 1-29-98RC

Certificate of Death

Reg. No. 97 41473

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): BABY "B" BOY BATSON

2. Date of Death: Month 12 Dey 9 Year 97

3. Time of Death: 1.30pm.

4a. Facility Name (If not institution, give street and number): HOWARD COUNTY GENERAL HOSPITAL

4b. City, Town, or Location of Death: COLUMBIA

4c. County of Death: HOWARD.

Funeral Director

5. Social Security Number: none

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): Yrs. | If Under 1 Year: Months | Days | If Under 24 Hrs.: Hours | Min. 13

8. Date of Birth (Month, Dey, Yeer): ~~January 9, 1998~~ DECEMBER 9, 1997

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street end Number: 5740 ~~Glag Flower Place~~ FLAG FLOWER PLACE

10f. Zip Code: 21045

10g. Citizen of Whet Country? U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Reca - American Indian, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondary (0-12) 0 | College (1-4or 5+) 0

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): none-infant

16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): Jacob Maynard

18. Mother's Name (First, Middle, Meiden Surname): Rebecca Batson

19a. Informent's Neme/Reletionship (Type, Print): Rebecca Batson - mother

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 5740 Flag Flower Place, Columbia, Maryland 21045

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremetion 3 [ ] Removal from State 4 [ ] Donetion 5 [X] Other (Specify) in state

20b. Place of Disposition (Name of cemetery, cremetory or other piece):

Dete:

20c. Location - City or Town, Stete:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Neme end Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset end Deeth

Immediate Ceuse (Finel disease or condition resulting in deeth)

e. EXTREME PREMATURITY.

Due to (or es a consequence of):

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

b. PRE-TERM LABOR.

Due to (or es e consequence of):

c.

Due to (or es e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

NO PRENATAL CARE.

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Wes en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings eveilable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Deeth (Check only one): Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Deeth: 1 [X] Netural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury et Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) end menner es steted. 2 [ ] **Medical Examiner:** On the basis of exemination end/or investigation, in my opinion, deeth occurred et the time, date end piece, end due to the ceuse(s) end manner stated.

29b. Signeture end title of certifier: Swati M. Saraiya.

29c. License number: D30511.

29d. Dete signed (Month, Dey, Year): 12/9/97.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): SWATI M. SARAIYA MD 11085 Little Patuxent Parkway Columbia, MD. 21044.

To the Hospital or Attending Physician: The law requires thet the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funerel director, page 2 should be detached for use es the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 29 1998

32. Registrar's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

97-7056-510
B.K.S

UNKNOWN 97-265
GLEN CARPENTER Items:23a part I,27,28a-f per MEO G- 757 3/11/98 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41474
Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Glen Carpenter
2. Date of Death (Month, Day, Year): DEC. 7, 1997
3. Time of Death: 9:50 AM
4a. Facility Name *(If not institution, give street and number)*: 1437 NORTH PATTERSON PARK AVENUE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: unknown
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)*: 34 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: July 18, 1963
9. Birthplace *(State or Foreign Country)*: unknown

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street end Number: 721 North Milton Avenue
10f. Zip Code: 21205
10g. Citizen of What Country?: U.S.A.

11. Marital Status: unknown — 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decadent Ever in U.S. Armed Forces? unknown — 1 [ ] Yes 2 [ ] No — If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) — 1 [ ] Yes 2 [X] No *Specify:*
14. Raca - American Indian, Bleck, White, etc. — *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)* — Elementary/Secondary (0-12): unknown — College (1-4or 5+): unknown
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unknown
16b. Kind of Business/Industry: unknown

17. Father's Name *(First, Middle, Last)*: unknown
18. Mother's Name *(First, Middle, Maiden Surname)*: unknown

19a. Informant's Name/Relationship *(Type, Print)*: unknown
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: unknown

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other *(Specify)* in state
20b. Place of Disposition *(Name of cemetery, crematory or other place)*:
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset end Death

Immediate Cause (Final disease or condition resulting in death): a. NARCOTIC AND ALCOHOL INTOXICATION

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditiona contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [XX] Other *(Specify)* VACANT HOUSE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [XX] Could not be determined
28a. Date of Injury *(Month, Day Year)*: found 12/7/97
28b. Time of Injury: found 9:45 A M
28c. Injury at Work? 1 [ ] Yes 2 [XX] No
28d. Describe how injury occurred: unknown
28e. Place of Injury - At home, farm, street, factory, offica building, etc. *(Specify)*: found in rear of vacant house
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: 1437 Patterson Park, Baltimore, Maryland

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [XX] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signeture end title of certifier:
29c. License number: O.C.M.E
29d. Date signed *(Month, Day, Year)*: DEC. 8, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 29 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 21,22,24a,25,26,27,29a Per PHY Film G755 1-28--98 ria

Certificate of Death

Reg. No. 97 41475

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): DANIEL WEBSTER DIXON

2. Date of Death (Month, Day, Year): DECEMBER 30, 1997

3. Time of Death: 7:44 AM

4a. Facility Name (If not institution, give street and number): Frederick Memorial Hospital

4b. City, Town, or Location of Death: Frederick

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: unknown

6. Sex: 1☒ M 2☐ F

7. Age (In yrs. last birthday): 65 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec. 17, 1932

9. Birthplace (State or Foreign Country): Florida

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Dickerson

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 6762 Ed Sears Road

10f. Zip Code: 20842

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown

16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): Louis Monroe White

18. Mother's Name (First, Middle, Maiden Surname): Rosabell Boyer

19a. Informant's Name/Relationship (Type, Print): unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: RONALD S. WADE, DIRECTOR

22. Name and Address of Facility: ~~State Anatomy Board Ronald S. Wade, Director~~ State Anatomy Board 655 W. Baltimore St. Baltimore, Maryland 21201

24a
25
26
27
29a

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. UREMIA — Approximate Interval: 2 wks

Due to (or as a consequence of):

b. RENAL FAILURE — Approximate Interval: 3 wks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. HTN — Approximate Interval: 1 year

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DIABETES mellitus type II

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☑ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D29591

29d. Date signed (Month, Day, Year): 12/30/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): 201 Thomas Johnson Drive Frederick MD 21702

State Registrar

31. Date filed (Month, Day, Year): JAN 28 1998

32. Registrar's Signature: Judith Davidson Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41476

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rouse Fetus A

2. Date of Death: Month JULY, Day 6, Year 1997

3. Time of Death: 05:00 AM

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

Funeral Director

5. Social Security Number: NONE

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday) Yrs.: If Under 1 Yaar: Months / Days; If Under 24 Hrs.: Hours 7 / Min. 10

8. Date of Birth (Month, Day, Year): July 6, 1997

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2412 Dorton Court

10f. Zip Code: 21230

10g. Citizen of What Country? USA

11. Maritel Status: 1☒ Navar Marriad 2☐ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yas 2☒ No If Yes, Give Yeer or Detas:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuben, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify: Black

14. Race - Americen Indien, Bleck, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grede completed): Elementery/Secondery (0-12): 0; College (1-4or 5+): None

16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired): Infant

16b. Kind of Business/Industry: Infant

17. Fether's Name (First, Middle, Last): Tavon Blackstone

18. Mother's Neme (First, Middle, Meiden Sumame): Tia Rouse

19a. Informant's Name/Relationship (Type, Print): Tia Rouse/Mother

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2412 Dorton Court Baltimore, Maryland 21230

20a. Method of Disposition: 1☐ Buriel 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Disposal

20b. Pleca of Disposition (Name of cemetery, cremetory or other plece): Johns Hopkins Hospital

Date: 7/9/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funerel Service Licensee:

22. Nama and Address of Facility: Johns Hopkins Hospital 600 N. Wolfe Street, Baltimore, Maryland 21287

Physician /Medical Examiner

23a. Part1. Entar tha disease, or complicetions that causad tha daath. Do not enter the mode of dying, such es cerdiac or respiratory arrast, shock, or heart feilure. List only one cause on each line.

Approximeta Intarval Between Onset end Deeth

Immediete Cause (Finel disaasa or condition rasulting in death): e. Extreme prematurity — 1hr. 10min.

Dua to (or as a consequence of):

Sequentially list conditions, if any, laading to immediata causa. Entar Underlying Cause (Disease or injury thet initieted evants resulting in death) Lest:

b. Due to (or es e consequanca of):

c. Due to (or es a consaquence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes en autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of ceuse of daath? 1☐ Yes 2☒ No

25. Wes case rafarred to medical exeminer? 1☐ Yas 2☒ No

26. Place of Daath (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpetient 3☐ DOA; Othar: 4☐ Nursing Homa 5☐ Rasidance 8☐ Other (Specify)

27. Mennar of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding Investigetion 6☐ Could not be determined

28a. Dete of Injury (Month, Day Year)

28b. Tima of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To tha best of my knowledga, daeth occurred at the time, dete end plece, end due to the causa(s) and mannar as steted. 2☐ **Medical Examinar:** On the besis of examinetion end/or investigation, in my opinion, deeth occurred et the time, data end place, and due to the cause(s) and menner steted.

29b. Signetura and title of certifier:

29c. Licanse number: D 43683

29d. Date signed (Month, Day, Year): 7/6/97

30. Nema end eddress of parson who completed cause of death (Item 23e) (Type, Print): JESSICA BIENSTOCK, M.D. JOHNS HOPKINS HOSPITAL, BALTIMORE, MD. 21287

State Registrar

31. Date Filed (Month, Day, Year): JAN 29 1998

32. Registrar's Signature:

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41477

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Rouse Fetus B

2. Date of Death: Month JULY Dey 6, Year 1997

3. Time of Death: 05:00 AM

4a. Facility Name (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death: BALTIMORE CITY

4c. County of Death:

Funeral Director

5. Social Security Number: NONE

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): Yrs.

If Under 1 Year: Months Days

If Under 24 Hrs.: Hours 7 Min. 10

8. Date of Birth (Month, Dey, Year): July 6, 1997

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. Stete: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 2412 Dorton Court

10f. Zip Code: 21230

10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12) 0; College (1-4or 5+) None

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Infant

16b. Kind of Business/Industry: Infant

17. Father's Name (First, Middle, Last): Tavon Blackstone

18. Mother's Name (First, Middle, Meiden Surname): Tia Rouse

19a. Informant's Name/Relationship (Type, Print): Tia Rouse / Mother

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 2412 Dorton Court, Baltimore, Maryland 21230

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify): Disposal

20b. Piece of Disposition (Name of cemetery, cremetory or other piece): Johns Hopkins Hospital

Date: 7/9/97

20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee:

22. Name end Address of Facility: 600 N. Wolfe Street, Baltimore, Md. 21287

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Extreme prematurity — 1hr. 10min.

Due to (or as a consequence of):

Sequentially list conditions, if eny, leading to Immediate ceuse. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as e consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performed? 1☒ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Wes cese referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospitel: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☒ **Certifying Phyaician:** To the best of my knowledge, death occurred et the time, dete end place, and due to the ceuse(s) end manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end manner stated.

29b. Signature and title of certifier:

29c. License number: D 43683

29d. Date signed (Month, Day, Year): 7/6/97

30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print): JESSICA BIENSTOCK, M.D. JOHNS HOPKINS HOSPITAL, BALTIMORE, MD. 21287

State Registrar

31. Date filed (Month, Dey, Year): JAN 29 1998

32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

97 41478

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Female Sherman
2. DATE OF DEATH (Month, Day, Year): 10 19 97
3. TIME OF DEATH: 1:15A M
4. SOCIAL SECURITY NUMBER: None
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN. 55
7. DATE OF BIRTH (Month, Day, Year): 10/19/97
8. BIRTHPLACE (State or Foreign Country): maryland
9a. FACILITY NAME (If not institution, give street and number): Prince Georges Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly
9c. COUNTY OF DEATH: prince Georges

RESIDENCE OF DECEDENT

10a. STATE: md
10b. COUNTY: prince Georges
10c. CITY, TOWN OR LOCATION: Lanham
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 9522 Worrell Avenue
10f. ZIP CODE: 20706
10g. CITIZEN OF WHAT COUNTRY? U.S.
11. MARITAL STATUS: Infant (1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced)
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): Infant — College (1-4 or 5+): Infant
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Infant
16b. KIND OF BUSINESS/INDUSTRY: Infant
17. FATHER'S NAME (First, Middle, Last): Ola I ABIWA
18. MOTHER'S NAME (First, Middle, Maiden Surname): Betty W. Sherman
19a. INFORMANT'S NAME (Type/Print): Betty W. Sherman
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9522 Worrell Avenue Lanham md 20706
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify): TO HOSPITAL
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place): PGHC — DATE: 10/30/97
20c. LOCATION — City or Town, State: CHEVERLY MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: PGHC. CHEVERLY MD 20785

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	prematurity	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	placental abruption	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 10/19/97
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Craig S. Cropp MD
29c. LICENSE NUMBER: D33593
29d. DATE SIGNED (Month, Day, Year): 1/23/98
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CRAIG S. CROPP, MD PRINCE GEORGES HOSPITAL
31. DATE FILED (Month, Day, Year): JAN 29 1998
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41479

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Streckfus

2. Date of Death: Month 10 Day 03 Year 97

3. Time of Death: 12:10 AM

4a. Facility Name (If not institution, give street and number): Genesis Eldercare - Randallstown

4b. City, Town, or Location of Death: RANDALLSTOWN

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 216-30-7333

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 6-10-11

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: N/A

10c. City, Town or Location: BALTIMORE

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 6623 LOCH RAVEN BLVD

10f. Zip Code: 21212

10g. Citizen of What Country? usa

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): +3; College (1-4or 5+): +3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): REG. NURSE

16b. Kind of Business/Industry: ST. AGNES HOSPITAL

17. Father's Name (First, Middle, Last): WILLIAM SCHMITZ

18. Mother's Name (First, Middle, Maiden Surname): ROSANNA THOMAS

19a. Informant's Name/Relationship (Type, Print): MRS. ANN KACZOROWSKI

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1299 RIVER CHASE DR. CHARLOTTESVILLE VA. 22901

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): HOLY CROSS CEM

Date: 10-6

20c. Location - City or Town, State: BALTO. CO. MD.

21. Signature of Funeral Service Licensee: Charles R. Kaczorowski

22. Name and Address of Facility: KACZOROWSKI FUNERAL HOME 1201 DUNDALK AVE BALTO. MD. 21222

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiorespiratory arrest

Due to (or as a consequence of):

b. Coronary Artery disease

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c. Alzheimer's disease

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number: D19402

29d. Date signed (Month, Day, Year): 10 9 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): S. DEV AHUJA 5400 OLD COURT RD RANDALLSTOWN

State Registrar

31. Date filed (Month, Day, Year): JAN 27 1998

32. Registrar's Signature: Judy Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To be Completed by Funeral Director

Medical Certification: To be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41480

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DONALD J. SCHOOLFIELD, JR.

2. Date of Death (Month, Day, Year): DECEMBER 27, 1997

3. Time of Death: 0047

4a. Facility Name *(If not institution, give street and number)*: PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 212-19-5961

6. Sex: 1 [X] M 2 [ ] F

7. Age *(In yrs. last birthday)*: 10 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 5/25/87

9. Birthplace *(State or Foreign Country)*: MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD

10b. County: Worcester

10c. City, Town or Location: Pocomoke

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 806 Lynnhaven Drive, #211

10f. Zip Code: 21851

10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0 | College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: N/A

16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: Donald J. Schoolfield, Sr.

18. Mother's Name *(First, Middle, Maiden Surname)*: Karen Mills

19a. Informant's Name/Relationship *(Type, Print)*: Karen Schoolfield, Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 806 Lynnhaven Drive, #211, Pocomoke, MD 21851

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Hall's Hill Cemetery | Date: 1/3/98

20c. Location - City or Town, State: Pocomoke, MD

21. Signature of Funeral Service Licensee: ▶ Samuel H. Cooper, Jr., per DVR

22. Name and Address of Facility: Cooper & Humbles Funeral Co., Inc. P.O. Box 176, Accomac, VA 23301

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CEREBRAL PALSY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. ASTHMA

Due to (or as a consequence of):

c. SEIZURE DISORDER

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

TRACHEOSTOMY

GASTROSTOMY

ENCEPHALOPATHY/PROFOUND MENTAL RETARDATION

23b. **Did tobacco use contribute to the cause of death?** 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death *(Check only one)*: Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury *(Month, Day, Year)*

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Christina T. McShea

29c. License number: D0051709

29d. Date signed *(Month, Day, Year)*: 1/19/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Christina T. McShea, MD 1201 Pemberton Dr. Salisbury, MD 21801

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 28 1998

32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 1 Per PHY Film G755 1-28-98 rja

Certificate of Death

Reg. No. 97 41481

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
~~West, Dorothy~~ DOROTHY WEST	08 / 31 / 97	1:50

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Brighton Manor Nursing Home	Baltimore, Md.	Baltimore City

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
213-26-8942	1☐M 2☒F	66 Yrs.			May 6, 1931	Maryland

Usual Residance of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland		Baltimore	1☒Yes 2☐No

10e. Street and Number	10f. Zip Code	10g. Citizan of What Country?
1601 N. Dukeland Street	21216	U.S.A.

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.)	14. Race - American Indian, Black, Whita, atc.
1☒Never Married 2☐Married 3☐Widowad 4☐Divorcad	1☐Yas 2☒No If Yas, Give Yaar or Datas:	1☐Yas 2☒No Specify:	Specify: black

15. Decedent's Education (Specify only highast grada completed)		16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired)	16b. Kind of Businass/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	0	Clothing presser	unknown

17. Father's Nama (First, Middle, Last)	18. Mothar's Nama (First, Middle, Maidan Surname)
Henry West	Helen Davis

19a. Informant's Name/Reletionship (Type, Print)	19b. Mailing Address (Street and Numbar or Rural Routa Number, City or Town, State, Zip Code)
unknown	unknown

20a. Method of Disposition	20b. Placa of Disposition (Nama of cemetery, cramatory or othar placa)	Data	20c. Location - City or Town, Stata
1☐Burial 2☐Cramation 3☐Removal from Stata 4☐Donation 5☒Othar (Specify) in-state			

21. Signature of Funaral Sarvica Licansee	22. Nama and Address of Facility
Joseph B. Van Sant	State Anatomy Board, 655 W. Baltimore Street Baltimore, MD 21201

Physician /Medical Examiner

23a. Partl. Enter the disaase or complications that caused the death. Do not enter the moda of dying, such as cardiac or raspiratory arrast, shock, or haart failure. List only ona causa on each lina.

		Approximata Interval Batween Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. asphyrxia 20 to laryngeal obstruction	
	Dua to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. laryngeal carcinoma	
	Due to (or as e consequanca of):	
	c.	
	Due to (or as a consequance of):	
	d.	

Part II. **Othar significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

cerebral vascular accident

hypertension

23b. **Did tobacco use contribute to the cause of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yas 2☒No	1☐Yas 2☐No

25. Was case referred to medical examiner?	26. Placa of Daath (Check only one)	
1☐Yes 2☒No	Hospital: 1☐Inpatiant 2☐ER/Outpatiant 3☐DOA	Othar: 4☒Nursing Homa 5☐Rasidance 6☐Othar (Specify)

27. Manner of Death	28a. Date of injury (Month, Day Year)	28b. Tima of Injury	28c. Injury at Work?	28d. Dascribe how injury occurred
1☒Natural 2☐Accident 3☐Suicide 4☐Homicida 5☐Pending investigation 6☐Could not be determined		M	1☐Yas 2☐No	
	28a. Placa of Injury - At home, farm, streat, factory, office building, atc. (Spacify)			28f. Location (Streat and Numbar or Rural Routa Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Phyaician:** To the best of my knowledga, daath occurrad at the time, data and placa, and due to the ceusa(s) and mannar as statad.
2☐ **Medical Examiner:** On the basis of exemination and/or investigetion, in my opinion, daath occurrad at tha tima, data and plece, and due to the ceusa(s) and mannar stated.

29b. Signature and title of certifier	29c. Licansa number	29d. Data signed (Month, Day, Year)
Wanda J. Clemmons M.D.	D35674	9/5/97

30. Name and eddrass of person who complated causa of death (Item 23a) (Type, Print)
Wanda Clemmons, M.D., 4820 Seton Drive, Baltimore, Md. 21215

State Registrar

31. Date filad (Month, Day, Year)	32. Registrar's Signatura
JAN 28 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 28a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41482

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: LAUREL S. BUCK

2. Date of Death Month: DEC Day: 31 Year: 97

3. Time of Death: 2235P

4a. Facility Name *(If not institution, give street and number)*: Suburban Hospital

4b. City, Town, or Location of Death: Bethesda

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 267-35-0756

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 34 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: May 10, 1963

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Bethesda

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10401 Grosvenor Place, #1022

10f. Zip Code: 20852

10g. Citizen of What Country?: United States

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): – College (1-4or 5+): 4

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Computer Technician

16b. Kind of Business/Industry: Hospital

17. Father's Name *(First, Middle, Last)*: Richard Sutton Buck, IV

18. Mother's Name *(First, Middle, Maiden Surname)*: Nancy Wilkerson

19a. Informant's Name/Relationship *(Type, Print)*: Nancy W. Buck/ Mother

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 5789 Greenock Road, Lothian, Maryland 20711

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Montgomery Crematorium, Inc. Date: January 7, 1998

20c. Location - City or Town, State: Bethesda, Maryland

21. Signature of Funeral Service Licensee: [signature] 000689

22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. OVERDOSE — 1 DAY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

25. Was case referred to medical examiner? 1☒ Yes 2☐ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☐ Natural 2☐ Accident 3☒ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day, Year)*: DEC 30 97

28b. Time of Injury: 1400 M

28c. Injury at Work? 1☐ Yes 2☒ No

28d. Describe how injury occurred: TOOK PILLS

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: HOME

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*: #10

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: D07099

29d. Date signed *(Month, Day, Year)*: JAN 1 98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS C. MAYLE 10415 TERNWOOD A BETHESDA MD 20817

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

97-7272-047
CIP
THEODORE L. LAUER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41483

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: THEODORE LEE LAUER
2. Date of Death Month Day Year: DECEMBER 17, 1997
3. Time of Death: 6:30AM
4a. Facility Name *(If not institution, give street and number)*: GREEN RUN HUNTING LODGE
4b. City, Town, or Location of Death: BERLIN
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 216-70-0825
6. Sex: 1☒M 2☐F
7. Age *(In yrs. last birthday)*: 43 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 2/19/54
9. Birthplace *(State or Foreign Country)*: MD

Usual Residence of Decedent

10a. State: MD
10b. County: Worcester
10c. City, Town or Location: Ocean City
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street end Number: 603 St. Louis Ave.
10f. Zip Code: 21842
10g. Citizen of What Country?: USA

11. Maritel Status: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* white

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12) / College (1-4or 5+): 2
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Auto Mechanic
16b. Kind of Business/Industry: Auto Repair Shop

17. Father's Neme *(First, Middle, Last)*: Winthrop Bellamy Lauer
18. Mother's Name *(First, Middle, Meiden Sumeme)*: Edna Peters

19e. Informent's Name/Relationship *(Type, Print)*: Susan Lauer/ Wife
19b. Meiling Address *(Street and Number or Rurel Route Number, City or Town, State, Zip Code)*: 603 St. Louis Ave. Ocean City, MD 21842

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removel from State 4☐Donation 5☐Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: Evergreen Cemetery
Dete: 12/20/97
20c. Location - City or Town, State: Berlin, MD

21. Signature of Funeral Service Licensee: Burke Burbage
22. Name and Address of Facility: Burbage Funeral Home 108 William St. Berlin, MD 21811

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line.

Approximate Intervel Between Onset and Deeth

Immediate Ceuse (Final disease or condition resulting in death)
a. Fatty Liver
Due to (or as e consequenca of):
b. Chronic Alcoholism

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequenca of):
c.
Due to (or as a consequenca of):
d.

Part II. **Other significant conditions** contributing to deeth but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cauas of death?** 1☐Yes 2☐No 3☐Probably 4☒Unknown

24e. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findinga aveileble prior to completion of cause of death? 1☒Yes 2☐No

25. Was case referred to medical examiner? 1☒Yes 2☐No
26. Piece of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☒Other *(Specify)* HUNTING LODGE
27. Manner of Death: 1☒Netural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rurel Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner es stated. 2☒ **Medical Examiner:** On the besis of exemination end/or Investigation, In my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated.
29b. Signature end title of certifier: Stephen S. Radentz MD
29c. License number: O.C.M.E.
29d. Date signed *(Month, Day, Year)*: DECEMBER 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 12 1998
32. Registrer's Signeture: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41484

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: CHARITA RENEE MILES

2. Date of Death Month / Dey / Yeer: 12 - 19 - 97

3. Time of Death: 2:05PM

4a. Facility Name *(If not institution, give street and number)*: 6720 Flagstaff Street

4b. City, Town, or Location of Death: Landover

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 216-15-2224

6. Sex: 1☐ M 2☐ F — X

7. Age *(In yrs. last birthday)*: 14 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Dey, Year)*: Sept. 29 1983

9. Birthplece *(State or Foreign Country)*: Wash. D.C.

Usuel Residence of Decedent

10a. Stete: Md.

10b. County: Prince Georges

10c. City, Town or Location: Landover

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street end Number: 6720 Flagstaff St.

10f. Zip Code: 20785

10g. Citizen of Whet Country?: U.S.A.

11. Meritel Status: 1☒ Never Merried 2☐ Merried 3☐ Widowed 4☐ Divorcad

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Yeer or Dates:

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*

14. Reca - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 9th — College (1-4or 5+):

16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: Student

16b. Kind of Business/Industry: None

17. Father's Neme *(First, Middle, Last)*: James R. Miles Jr.

18. Mother's Neme *(First, Middle, Meiden Surneme)*: Carolyn Kelly

19a. Informent's Neme/Reletionship *(Type, Print)*: Carolyn M. Miles /Mother

19b. Melling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 6720 Flagstaff St. Landover Md. 20785

20a. Method of Disposition: 1☒ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donetion 5☐ Other *(Specify)*

20b. Piece of Disposition *(Neme of cemetery, cremetory or other piece)*: Ft. Lincoln Cemetery

Dete: 12/23/97

20c. Location - City or Town, State: Brentwood Md.

21. Signeture of Funerel Service Licensee: Belva J. Jenkins

22. Neme end Address of Facility: Johnson & Jenkins, 716 Kennedy St. N.W. Wash. 20011

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complidations thet caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only one cause on each line.

Approximete Interval Between Onset and Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth)

a. Malignant neoplasm of

Due to (or es e consequenca of):

b. Glioblastoma multiforme

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest

Due to (or es e consequence of):

c. with necrosis

Due to (or es e consequenca of):

d. (b) metastasis of above tumor

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert f.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings aveileble prior to completion of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☒ No

28. Piece of Deeth *(Check only one)*: Hospitel: 1☐ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other *(Specify)*

27. Menner of Deeth: 1☒ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Dete of Injury *(Month, Dey Year)*

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, Stete)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Phyeician:** To the best of my knowledge, death occurred et the time, dete end piece, end due to the cause(s) end manner es steted. 2☐ **Medical Examiner:** On the basis of exeminetion and/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the cause(s) end menner steted.

29b. Signeture end title of certifier: Bellay Jefferson

29c. License number: D 33204

29d. Date signed *(Month, Dey, Year)*: 1/16/98

30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): Brenda Petts-Bellamy MD Landover Mall Prom4. Landover MD 20785

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: JAN 16 1998

32. Registrar's Signature: John Thompson Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

(4)

VOID

CERTIFICATE #

97-41485

SEE

Julia Evans Passano

CERTIFICATE # Died 1/6/98

97-6831-033
B.K.S

UNKNOWN 97-257 MICHAEL R. ASKINS
Items:23a part I,27 per MEO G-757 3/11/98 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41486
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Michael R. Askins

2. Date of Death (Month, Day, Year): NOV. 25, 1997

3. Time of Death: 12:15 PM

4a. Facility Name (If not Institution, give street and number): ROUTE# 95 & ST.BARNABAS ROAD

4b. City, Town, or Location of Death: OXON HILL

4c. County of Death: PRINCE GEORGES

Funeral Director

5. Social Security Number: unknown

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 38 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Nov. 24, 1959

9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: Maryland

10b. County: unknown

10c. City, Town or Location: Washington

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 203 North Street, N.W.

10f. Zip Code: unknown

10g. Citizen of What Country?: U.S.A.

11. Marital Status: unknown
1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces?: unknown
1 [ ] Yes 2 [ ] No
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc.
Specify: Black

15. Decedent's Education (Specify only highest grade completed)
Elementery/Secondary (0-12): unknown
College (1-4or 5+): unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown

16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Mellie Carter/sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1730 7th Street, Washington, D.C.

20a. Method of Disposition
1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State
4 [ ] Donation 5 [X] Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. SEIZURE DISORDER AND FATTY LIVER

Due to (or as e consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?
1 [ ] Yes 2 [✓] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed?
1 [✓] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death?
1 [✓] Yes 2 [ ] No

25. Was case referred to medical examiner?
[X] Yes 2 [ ] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence [X] Other (Specify) FIELD

27. Manner of Death
1 [X] Natural 5 [ ] Pending Investigation
2 [ ] Accident 6 [ ] Could not be determined
3 [ ] Suicide
4 [ ] Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one)
1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
[X] **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29b. Signature end title of certifier: Wayne Bell MD

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): NOV. 26, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
MARY ANN B. KOPSH 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 05 1998

32. Registrer's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41487

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): ALEXIS AVENT
2. Deta of Deeth — Month: October Day: 2 Year: 1997
3. Time of Deeth: 5:05 P.M
4a. Facility Neme (If not institution, give street end number): Southern Maryland Hospital
4b. City, Town, or Locetion of Deeth: Clinton
4c. County of Death: Prince Georges

Funeral Director

5. Sociel Security Number: 577-80-3679
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthdey): 34 Yrs. — If Under 1 Yeer: Months / Deys — If Under 24 Hrs.: Hours / Min.
8. Deta of Birth (Month, Dey, Yeer): 5-13-63
9. Birthplece (State or Foreign Country): N.J.

Usuel Residence of Decedent

10a. Stete: MD
10b. County: P.G.
10c. City, Town or Location: Forestville
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Streef and Number: 6022 Surrie Sq. LANE #101
10f. Zip Code: 20747
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Wes Decedent Evar in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Yaer or Detes:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - Amarican Indian, Bieck, White, atc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) — Elementery/Secondary (0-12): — College (1-4or 5+): 2
16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Word Processor
16b. Kind of Business/Industry: Private
17. Fethar's Neme (First, Middle, Last): Alex Avent
18. Mother's Name (First, Middle, Meiden Sumama): Myrdes LAWSON
19a. Informent's Name/Reletionship (Type, Print): Cynthia Edwards (sister)
19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 6022 Surrie Sq. Lane #101 - Forestville, MD 20747
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremetion 3 [ ] Removal from Stete 4 [ ] Donetion 5 [ ] Other (Specify)
20b. Piece of Disposition (Neme of cemetary, cremetory or other piece): Chesapeake Crematory
Dete: 10/4/97
20c. Location - City or Town, Stete: Bettsville, MD.
21. Signature of Funaral Service Licensee: Janice Edwards
22. Neme end Addrass of Fecility: Hodges Edwards 3910 Silver Hill Rd. Suitland, MD

Physician /Medical Examiner

23. Part I. Enter the disease, or complicetions that caused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on eech line.

Approximete Intervel Between Onset end Deeth

Immedlete Ceuse (Finel disease or condition resulting in deeth)
e. Pril. Pn. — 6 days

Due to (or es e consequence of):
b. AIDS

Sequenfially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Last
Dua to (or es e consequence of):
c. Oral Candidiasis
Due to (or es e consequence of):
d. Renal Failure

Part II. **Other elgnificant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Hypokalemia
Anemia

23b. Did tobacco use contribute to the cauee of death? 1 [ ] Yee 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24e. Wes an eutopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Wes case referred to medical exeminer? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one) — Hospitel: 1 [X] Inpatient 2 [ ] ER/Outpetient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. Menner of Deeth: 1 [X] Neturel 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigetion 6 [ ] Could not be determined
28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury et Work? 1 [ ] Yas 2 [ ] No
28d. Describe how Injury occurred
28e. Piece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end piece, end due to the ceuse(s) and manner as steted. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigetion, in my opinion, death occurred et the time, dete end piece, end due to the ceuse(s) end menner steted.
29b. Signature end title of certifier: [illegible] MD attending
29c. Licansa number: D24208
29d. Dete signed (Month, Day, Year): Feb 2, 1998
30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print): ABULHASAN. OANSARI MD 8926 Woodyard Rd #101 Clinton MD

State Registrar

31. Dete filed (Month, Dey, Yeer): FEB 03 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

RB

2

97-6477-510
AM
MICHAEL
DORSEY

Items: 23 part I,27,28a-f per MEO G-755 1/30/98 reb

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41488

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MICHAEL DARRELL Dorsey
2. Date of Death Month Day Year: NOVEMBER 10, 1997
3. Time of Death: 0825 A
4a. Facility Name (If not institution, give street and number): 2212 DIVISION ST.
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 217-84-0709
6. Sex: 1☒M 2☐F
7. Age (In yrs. last birthday): 27 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): MARCH 13, 1969
9. Birthplace (State or Foreign Country): BALTIMORE, md.

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: N/A
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 1915 East Fairmount Avenue
10f. Zip Code: 21231
10g. Citizen of What Country?: USA

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indien, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondery (0-12): 8th grade | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): ROOFER
16b. Kind of Business/Industry: Morris Grenberg Co.

17. Father's Name (First, Middle, Last): Michael Porter
18. Mother's Name (First, Middle, Maiden Surname): Lenoria Dorsey

19a. Informent's Name/Relationship (Type, Print): Helen Porter / Grandmother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Greenery ct., RandallsTown, md.

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Voshells Cemetery
Date: 11/17/97
20c. Location - City or Town, State: Dundalk, md.

21. Signature of Funeral Service License: [signature] pa.
22. Name end Address of Facility: Unity Funeral Home 108 W. North Ave, 21201

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feilure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. COCAINE AND NARCOTIC INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☒Yes 2☐No
24b. Were autopsy findings available prior to completion of ceuse of death? 1☒Yes 2☐No

25. Was cese referred to medical exeminer? 1☒Yes 2☐No
26. Place of Death (Check only one): Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 8☒Other (Specify) VACANT HOUSE

27. Manner of Deeth: 1☐Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation ☒Could not be determined
28a. Date of Injury (Month, Day Year): FOUND ON 11/10/97
28b. Time of Injury: FOUND AT 8:25 A M
28c. Injury et Work? 1☐Yes ☒No
28d. Describe how Injury occurred: UNKNOWN
28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify): FOUND IN A VANCANT HOUSE
28f. Location (Street and Number or Rural Route Number, City or Town, State): 2212 DIVISION ST. BALTIMORE, MARYLAND

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2☒ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner stated.

29b. Signature end ~~title of certifier~~: [signature]
29c. License number: OCME
29d. Dete signed (Month, Day, Year): NOVEMBER 10, 1997

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print): David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 29 1998
32. Regi[illegible] Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: Tha law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: Aftar this certificate has been signed by the attending physician and completely filled in by tha funeral director, page 2 should be detached for usa as tha burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41489

Item: 20b Per Md Film G-756 2-2-98RC

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Data of Death Month	Day	Year	3. Time of Death
Angel Yanay Drummond	10	16	97	0700

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
ST JOSEPH MEDICAL CENTER	Towson	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar Months	Days	If Under 24 Hrs. Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
	1☐ M 2☒ F	26 min Yrs.				26	10-16-97	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	BALTIMORE	Towson	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizan of What Country?
1605 Wadsworth Way	21239	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dacedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puarto Rican, atc.)	14. Race - American Indian, Black, Whita, atc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Yeer or Dates:	1☐ Yes 2☒ No Specify:	Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)		16a. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired)	16b. Kind of Business/Industry
Elemantary/Secondary (0-12)	Collaga (1-4or 5+)		
MA	MA	N/A	N/A

17. Father's Name (First, Middla, Last)	18. Mother's Name (First, Middle, Maidan Surname)
Terry Recardo Robertson	Lillie Drummond

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
(Mother) Lillie Jane Drummond	1605 Wadsworth Way, Baltimore, Md. 21239

20a. Method of Disposition	20b. Place of Disposition (Name of cemetary, crematory or other place)	Data	20c. Location - City or Town, Steta
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Holy Redeemer	4/28/98	Baltimore, Md.

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	St. Joseph Medical Center Towson, Md. 21204

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enlar tha disease, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or raspiretory arrest, shock, or heart failure. List only one causa on eech line.

Approximata Interval Between Onsat and Death

Immediate Cause (Finel disaase or condition resulting in death)

a. Prematurity

Dua to (or as a consequence of):

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Causa (Disaasa or Injury thet Initiated events resulting in death) Last

b. Premature Rupture of membranes

Dua to (or as a consequence of):

c. Premature Labar

Due to (or as a consequance of):

d.

Part II. **Other eignificant conditiona** contributing to death but not resulting in the underlying cause givan in Part I.

23b. Did tobacco uee contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yas 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Mannar of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Panding Investigation 6☐ Could not be datarminad		M	1☐ Yes 2☒ No	

28e. Place of Injury - At home, farm, straat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Cartifiar (Check only one) 1☒ **Cartifying Physician:** To tha best of my knowledge, daath occurred at tha tima, data and place, and dua to tha cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signed (Month, Day, Year)
▶ Jerry Maszarose CNM	R 104242	10-16-97

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Terry maszarose CNM 1900 morning Glory Dr Finksburg md 21048

State Registrar

31. Data filad (Month, Day, Year)	32. Registrar's Signature
FEB 02 1998	▶ Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item#24,25,26,27 per Phy G756 2/3/98 EW

Certificate of Death

Reg. No. 97 41490

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
RICHARD HAROLD SHANNON	DEC 28 1997	10:47 AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
1403 Chilton Drive	Silver Spring	Montgomery

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
127-28-0177	1☒ M 2☐ F	60 Yrs.			Oct. 7, 1937	New York

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Montgomery	Silver Spring	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1403 Chilton Drive	20904	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	5+	Engineer	Military

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
James Herold Shannon	Cecilia Agnas Scully

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Audrey J. Shannon/wife	1403 Chilton Drive, Silver Spring, Maryland 20904

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Ronald S. Wade, Director	State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. ESOPHAGEAL CANCER	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): b.	
	Due to (or as a consequence of): c.	
	Due to (or as a consequence of): d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
James A. Butler MD	MD-00021881 (WA)	JAN 5 1998

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
JAMES A. BUTLER, CDR, MC, USN
NATIONAL NAVAL MEDICAL CENTER
BETHESDA MD 20889-5600

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 03 1998	Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41491

Item #21,22,24a,25 perSAB G756 2/3/98 EW

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: EDWARD ALBERT TRENCHI

2. Date of Death Month Day Year: December 25, 1997

3. Time of Death: 7:35 AM

4a. Facility Name *(If not institution, give street and number)*: 1709 Wilmart Drive

4b. City, Town, or Location of Death: Rockville

4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 047-14-1086

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 74 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Feb. 4, 1923

9. Birthplace *(State or Foreign Country)*: Connecticut

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Rockville

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: 1709 Wilmart Drive

10f. Zip Code: 20852

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐Never Married 2☐Married 3☒Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No If Yes, Give Year or Dates: 1943-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12; College (1-4or 5+): 3

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: unknown

16b. Kind of Business/Industry: Post Office

17. Father's Name *(First, Middle, Last)*: Peter Trenchi

18. Mother's Name *(First, Middle, Maiden Surname)*: Evelyn Gangi

19a. Informant's Name/Relationship *(Type, Print)*: Emma Trenchi/sister

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1312 George Mason Drive, Arlington, Virginia 22204

20a. Method of Disposition: 1☐Burial 2☐Cremation 3☐Removal from State 4☒Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade Director

22. Name and Address of Facility: State Anatomy Board 655 W.Baltimore ST Baltimore MD 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC RENAL CANCER — 1 YEAR

Due to (or as a consequence of):

b. RENAL CELL CARCINOMA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☐Inpatient 2☐ER/Outpatient 3☐DOA; Other: 4☐Nursing Home 5☒Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD

29c. License number: D35635

29d. Date signed *(Month, Day, Year)*: January 05, 1998

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): JOSEPH KAPLAN 18111 Prince Phillip Dr. OLNEY, MD 20832

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 03 1998

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

#22 #24a 25

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41492

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Henry L. Young Sr.

2. Data of Death: Month December Day 29 Yaar 1997

3. Tima of Death: 14:25

4a. Facility Nama (If not institution, giva street and number): Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Daath: Baltimore

4c. County of Death: N/A

Funeral Director

5. Social Security Numbar: 220-05-8732

6. Sax: 1☒ M 2☐ F

7. Aga (In yrs. last birthday): 76 Yrs.

If Undar 1 Yaar: Months ____ Days ____

If Undar 24 Hrs.: Hours ____ Min. ____

8. Data of Birth (Month, Day, Yaar): Oct. 10, 1921

9. Birthplaca (Stata or Foreign Country): Maryland

Usual Rasidanca of Decedent

10a. Stata: MD

10b. County: Baltimore

10c. City, Town or Location: Dundalk

10d. Inside City Limits: 1☐ Yas 2☒ No

10e. Street and Number: 1948 Inverton Road

10f. Zip Coda: 21222

10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Navar Marriad 2☐ Marriad 3☒ Widowad 4☐ Divorcad

12. Was Dacedant Evar in U.S. Armed Forcas? 1☒ Yas 2☐ No If Yas, Giva Yaar or Datas:

13. Was Dacedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yas 2☒ No Specify:

14. Race - American Indian, Black, Whita, atc. Specify: White

15. Decadant's Education (Specify only highast grada completed)

Elementary/Secondary (0-12): 8th

Collaga (1-4or 5+):

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired): Machinist

16b. Kind of Businass/Industry: Locke Insulator's

17. Fathar's Nama (First, Middle, Last): John Young

18. Mothar's Nama (First, Middle, Maidan Surnama): Helen Tucker

19a. Informant's Name/Ralationship (Type, Print): Dale Young Sr./Son

19b. Mailing Addrass (Street and Numbar or Rural Routa Numbar, City or Town, Stata, Zip Coda): 1948 Inverton Road, Baltimore, MD 21222

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar (Specify)

20b. Placa of Disposition (Nama of camatary, cramatory or other placa): Parkwood Cemetery Data 1/2/98

20c. Location - City or Town, Stata: Baltimore, MD

21. Signatura of Funaral Sarvica Licansaa: R. Terry Connelly

22. Nama and Address of Facility: Connelly Funeral Home of Essex 300 Mace Ave., Baltimore MD 21221

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Entar tha diseases or complications that causad the death. Do not antar tha mode of dying, such as cardiac or raspiretory arrast, shock, or haart failura. List only ona cause on each lina.

Approximate Interval Between Onsat and Death

Immediata Causa (Final disease or condition resulting in death)

a. Coronary artery disease

Due to (or as a consequence of):

Sequantially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avants rasulting in daath) Last

b. Atherosclerosis years

Dua to (or as a consequanca of):

c.

Dua to (or as a consequanca of):

d.

Part II. **Other significant conditions** contributing to death but not rasulting in tha undarlying causa givan in Part I.

Hypertension

Abdominal surgery

23b. Did tobacco use contribute to the causa of death? 1☐ Yas 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy parformad? 1☐ Yas 2☒ No

24b. Ware autopsy findings available prior to compiation of causa of daath? 1☐ Yas 2☒ No

25. Was case rafarrad to medical examiner? 1☐ Yas 2☒ No

26. Placa of Daath (Check only ona)

Hospital: 1☐ Inpatiant 2☒ ER/Outpatiant 3☐ DOA

Othar: 4☐ Nursing Homa 5☐ Residanca 6☐ Othar (Specify)

27. Mannar of Daath: 1☒ Natural 2☐ Accidant 3☐ Suicida 4☐ Homicida 5☐ Panding Invastigation 6☐ Could not be datarminad

28a. Data of Injury (Month, Day Yaar)

28b. Tima of Injury M

28c. Injury at Work? 1☐ Yas 2☐ No

28d. Dascriba how injury occurrad

28a. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

28f. Location (Streat and Numbar or Rural Routa Numbar, City or Town, Stata)

29a. Certifiar (Check only one) 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurrad at tha tima, data and placa, and dua to tha causa(s) and mannar as stated. 2☐ **Madical Examinar:** On tha basis of examination and/or invastigation, in my opinion, death occurrad at tha tima, data and placa, and dua to tha cause(s) and mannar statad.

29b. Signatura and title of cartifiar: Thomas W. Shields MD

29c. Licansa number: N9474

29d. Data signad (Month, Day, Yaar): 12/30/1997

30. Nama and address of parson who completad causa of daath (Itam 23a) (Type, Print): THOMAS W. SHIELDS, M.D. % Johns Hopkins Hospital, 600 N. Wolfe St.

State Registrar

31. Data filad (Month, Day, Yaar): JAN 30 1998

32. Registrar's Signatura: Julia Davidson-Randall

To the Hospital or Attending Physician: The law requires that the death certificate be recorded within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41493
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): EDWARD LEE HALL, SR.
2. Date of Death: Month DEC. Day 25 Year 1997
3. Time of Death: 10:45 AM
4a. Facility Name (If not institution, give street and number): SNOWHILL NURSING & REHAB. CENTER
4b. City, Town, or Location of Death: SNOWHILL
4c. County of Death: WORCESTER

Funeral Director

5. Social Security Number: 218-20-8314
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 69 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): OCT. 8, 1928
9. Birthplace (State or Foreign Country): STOCKTON, MD.

Usual Residence of Decedent

10a. State: MD.
10b. County: WORCESTER
10c. City, Town or Location: SNOWHILL
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 405 MAPLE HILL
10f. Zip Code: 21863
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: AFRO-AMERICAN

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 7th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: LUMBERMAN

17. Father's Name (First, Middle, Last): BURTON HALL
18. Mother's Name (First, Middle, Maiden Surname): LULA ?

19a. Informant's Name/Relationship (Type, Print): LINDA RICHARDSON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 702 E. 6th STREET; WILMINGTON, DEL. 19801

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): SHILOH UM CHURCH/JOHNSON Date: 12-29
20c. Location - City or Town, State: POCOMOKE , MD.

21. Signature of Funeral Service Licensee: Loretta B. Jolley
22. Name and Address of Facility: JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD; SALISBURY, MD. 21801

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Arteriosclerotic Cardiovascular Disease	2 yrs
Due to (or as a consequence of): b.	Insulin Dependent Diabetes Mellitus	5 yrs
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Vascular Type Senile Dementia
Peripheral Vascular Disease
Essential Hypertension

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gregorio M. Belloso M.D.
29c. License number: D29505
29d. Date signed (Month, Day, Year): 12-25-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): GREGORIO M. BELLOSO, M.D., 5302 CHINABERRY DRIVE, SALISBURY, MD 21801

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1998
32. Registrar's Signature: Jabi Chrichton-Roberts

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41494

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): PAUL M. JOHNSTONE

2. Date of Death: Month DEC Day 17 Year '97

3. Time of Death: 1709

4a. Facility Name (If not Institution, give street and number): UNIV. of MARYLAND MED. SYSTEM

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: BALTIMORE

Funeral Director

5. Social Security Number: 559-38-4934

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 72 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Aug. 29, 1925

9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: Maryland

10b. County: Talbot

10c. City, Town or Location: St. Michaels

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 24181 Old House Cove Rd.

10f. Zip Code: 21663

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Aeronautical Engineer

16b. Kind of Business/Industry: Eastern Airlines

17. Father's Neme (First, Middle, Last): Paul M. Johnstone Sr.

18. Mother's Name (First, Middle, Maiden Surname): Marjorie Scott

19a. Informant's Name/Relationship (Type, Print): Joan Chandler Johnstone Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 24181 Old House Cove Rd. St. Michaels, Md. 21663

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Capitol Crematory | Date: Dec. 19, 1997

20c. Location - City or Town, State: Dover, Delaware

21. Signeture of Funeral Service Licensee: Harrison E Leonard

22. Name and Address of Facility: Harrison E. Leonard Funeral Home 312 S, Talbot St. St. Michaels, Maryland 21663

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	CEREBRAL HERNIATION SYNDROME	36 HRS
Due to (or as a consequence of):		
b.	CEREBRAL EDEMA	36 HRS
Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest — Due to (or as a consequence of): c.	INTRACEREBRAL HEMORRHAGE	36 HRS
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contributa to the causa of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of ceuse of death? 1 [ ] Yes 2 [X] No

25. Was cese referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, In my opinion, death occurred et the time, date and place, and due to the cause(s) end menner stated.

29b. Signature and title of certifier: MD

29c. License number: P 10252

29d. Date signed (Month, Day, Year): DEC. 17, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): COOK, JUDSON H. MD 22 SOUTH GREENE ST, BALTIMORE, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 06 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 4 1495

Jewett, Ruby M.
Baltimore, Maryland 21215-0020

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): RUBY MOZELLA JEWETT
2. Date of Death (Month, Day, Year): December 31 1997
3. Time of Death: 12:15 p.
4a. Facility Name (If not institution, give street and number): The Memorial Hospital at Easton
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot

Funeral Director

5. Social Security Number: 140-10-7005 B
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 76 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Dec. 29, 1921
9. Birthplace (State or Foreign Country): South Carolina

Usual Residence of Decedent

10e. State: Maryland
10b. County: Talbot
10c. City, Town or Location: St. Michaels
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 103 W. Marengo St.
10f. Zip Code: 21663
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Statistical Clerk
16b. Kind of Business/Industry: N. Y. State

17. Father's Name (First, Middle, Last): John Lollis
18. Mother's Name (First, Middle, Maiden Surname): Mary Lollis

19a. Informant's Name/Relationship (Type, Print): Hamilton S. Jewett Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 103 W. Marengo St. St. Michaels, Md. 21663

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Maryland Veterans Cem. E. Shore | Date: Jan 5, 1998
20c. Location - City or Town, State: Hurlock, Maryland

21. Signature of Funeral Service Licensee: Harrison E. Leonard
22. Name and Address of Facility: Harrison E. Leonard Funeral Home 312 S. Talbot St. St. Michaels, Md. 21663

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	SEPSIS	DAYS.
Due to (or as a consequence of): b.	RENAL FAILURE.	MONTHS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): c.	HYPERTENSION.	YEARS
d.	CORONARY ARTERY DISEASE.	YEARS.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

STATUS POST CEREBRAL VASCULAR EVENT.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Daniel E. Makas
29c. License number: H48241
29d. Date signed (Month, Day, Year): 12/31/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Daniel E. Makas M.D. 508 Idlewild Ave. Easton, Maryland 21601

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): JAN 05 1998
32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 4 1496

Certificate of Death

Reg. No.

ILETHEA KENNEDY

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

1. Decedent's Name *(First, Middle, Last)*: Ilethea Brown Kennedy
2. Date of Death (Month, Day, Year): Dec 31 1997
3. Time of Death: 3:36P
4a. Facility Name *(If not institution, give street and number)*: The Memorial Hospital
4b. City, Town, or Location of Death: Easton
4c. County of Death: Talbot
5. Social Security Number: 215-58-6125
6. Sex: 1☐M 2☒F
7. Age *(In yrs. last birthday)*: 46 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth *(Month, Day, Year)*: 05-23-1951
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Caroline
10c. City, Town or Location: 302 Seymour Dr. , Greensboro
10d. Inside City Limits: 1☒Yes 2☐No
10e. Street and Number: 302 Seymour Dr.
10f. Zip Code: 21639
10g. Citizen of What Country?: USA
11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12th; College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Dietary
16b. Kind of Business/Industry: Caroline County
17. Father's Name *(First, Middle, Last)*: Harry Lee Brown
18. Mother's Name *(First, Middle, Maiden Surname)*: Virginia Rue
19a. Informant's Name/Relationship *(Type, Print)*: Christine Scarborough(grandmother)
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 410 Strawberry Ct., Ridgely,Maryland 21660
20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Sandtown Cemetery
Date: 01/10/98
20c. Location - City or Town, State: Hillsboro,maryland
21. Signature of Funeral Service Licensee ▶ [signature]
22. Name and Address of Facility: Bennie Smith Funeral Home P.O.Box 1687, Easton,Maryland 21601

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) e.	Sepsis	4 wks
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b.	cerebrovascular accident	4 wks
Due to (or as a consequence of):		
c.		
Due to (or as a consequence of):		
d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: chronic renal failure Hypertension congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other *(Specify)*

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending Investigation 6☐Could not be determined

28a. Date of Injury *(Month, Day, Year)*
28b. Time of Injury
28c. Injury at Work? 1☐Yes 2☐No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29e. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier ▶ [signature]
29c. License number: 039749
29d. Date signed *(Month, Day, Year)*: 1/1/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): David G Oliver MD 503 Dutchmans Lane Easton MD 21601

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 07 1998
32. Registrar's Signature ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 20b per F.H. G-756 2/5/98 reb

Certificate of Death

Reg. No. 97 41497

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): John Roswell Newby

2. Dete of Deeth — Month: December; Dey: 17; Yeer: 1997

3. Time of Death: 16:50

4e. Feciliity Neme (If not institution, give street end number): Washington County Hospital

4b. City, Town, or Location of Deeth: Hagerstown

4c. County of Deeth: Washington

Funeral Director

5. Social Security Number: 114-01-5695

6. Sex: 1☐M 2☐F — X

7. Age (In yrs. last birthday): 84 Yrs.

If Under 1 Year: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): Dec. 7, 1913

9. Birthplece (Stete or Foreign Country): S.D.

Usuel Residence of Decedent

10e. Stete: N.Y.

10b. County: Onondaga

10c. City, Town or Location: Camillus , Syracuse

10d. Inside City Limits: 1☐Yes 2☐No — XX

10e. Street end Number: 304 Inwood Dr.

10f. Zip Code: 13219

10g. Citizen of What Country? USA

11. Meritel Stetus: 1☐Never Married 2☐Married XX3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No — If Yes, Give Yeer or Dete: WWII

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grede completed) — Elementery/Secondery (0-12): 12 — College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Section Foreman

16b. Kind of Business/Industry: Railroad

17. Fether's Neme (First, Middle, Last): John T Newby

18. Mother's Name (First, Middle, Meiden Surneme): Elenora Briggs

19e. Informent's Neme/Reletionship (Type, Print): Nancy Newby/ daughter

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 304 Inwood Dr. Syracuse, NY. 13219

20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removel from Stete 4☐Donetion 5☐Other (Specify)

20b. Piece of Disposition (Neme of cemetery, crematory or other piece): Center Lisle Cem.

Dete: 5/98

20c. Location - City or Town, State: Center Lisle, NY

21. Signeture of Funerel Service Licensee: ▶ Fred C. Burner

22. Neme end Address of Feciliity: Burner Trade Services Hagerstown, Md. 21740, 1037 Dual Place

Physician /Medical Examiner

23e. Pert I. Enter the diseese, or complications thet ceused the deeth. Do not enter the mode of dying, such es cerdiec or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Intervel Between Onset end Deeth

Immediete Ceuse (Finel disease or condition resulting in deeth) e. Myocardial infarction — 24hours.

Due to (or es a consequence of):

Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Lest

b. Due to (or es e consequence of):

c. Due to (or es e consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive heart failure

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24e. Wes an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings aveileble prior to completion of cause of death? 1☐Yes 2☐No

25. Wes case referred to medical exeminer? 1☐Yes 2☒No

26. Piece of Death (Check only one) — Hospitel: 1☒Inpetient 2☐ER/Outpetient 3☐DOA — Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Menner of Death: 1☐Nelurel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Piece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒Certifying Physicien: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) end menner es steted. 2☐Medical Examiner: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, and due to the ceuse(s) and menner steted.

29b. Signeture end title of certifier: ▶ SAMUEL CHAN, MD

29c. License number: D36655

29d. Dete signed (Month, Dey, Yeer): December 17 1997

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): 1185 MT ALTA RD HAGERSTOWN, MD 21740

State Registrar

31. Dete filed (Month, Dey, Yeer): DEC 19 1997

32. Registrer's Signeture: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

John Newby

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41498

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VERNON THOMAS
2. Date of Death (Month, Day, Year): Dec. 31 1997
3. Time of Death: 1800
4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER
4b. City, Town, or Location of Death: SALISBURY
4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 214-16-4100
6. Sex: X M 2 F
7. Age (In yrs. last birthday): 71 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): DEC. 15, 1926
9. Birthplace (State or Foreign Country): ACCOMAC, VA.

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD.
10b. County: TALBOT
10c. City, Town or Location: GRASONVILLE
10d. Inside City Limits: 1 Yes 2 X No
10e. Street and Number: P.O. BOX 102
10f. Zip Code: 21638
10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 Married 3 X Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 X No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): NONE | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): LABORER
16b. Kind of Business/Industry: FIELD WORK

17. Fether's Neme (First, Middle, Last): THOMAS GEORGE
18. Mother's Name (First, Middle, Meiden Surneme): MARY E. THOMAS

19a. Intormant's Name/Relationship (Type, Print): SADIE PURNELL
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): RTE. #2, BOX 94A: MILLSBORO, DEL. 19966

20a. Method ot Disposition: 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place ot Disposition (Name of cemetery, crematory or other place): SALISBURY CREMATORY
Date: 1-8-98
20c. Location - City or Town, State: SALISBURY, MD. 21801

21. Signature of Funeral Service Licensee: Loretta B. Jolley
22. Name and Address of Feciliti: JOLLEY MEMORIAL CHAPEL 1213 JERSEY ROAD: SALISBURY, MD. 21801

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heert teilure. List only one cause on each line.

Approximete Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. Aspiration Pneumonia

Due to (or as a consequence ot):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury thet initiated events resulting in deeth) Last

b. Due to (or as a consequenca of):

c. Due to (or es a consequenca ot):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Dementia

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 X No

24b. Were autopsy findings available prior to completion ot cause ot death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 X No

26. Piece of Death (Check only one): Hospital: 1 Inpatient 2 X ER/Outpatient 3 DOA | Other: 4 Nursing Home 5 Residenca 6 Other (Specify)

27. Menner ot Death: 1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Dey Yeer)
28b. Time ot Injury M
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Placa of injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 **Certifying Physician:** To the best ot my knowledge, deeth occurred et the time, date and placa, end due to the cause(s) and manner as stated. 2 **Medicat Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, dete end place, and due to the cause(s) end manner stated.

29b. Signeture and title of certifier: Paul R Fleury
29c. License number: D24872
29d. Dete signed (Month, Day, Year): 12/31/97

30. Name and address ot person who completed cause ot deeth (Item 23a) (Type, Print): PAUL R FLEURY 560 RIVERSIDE DR A204 SALISBURY MD

State Registrar

31. Date filed (Month, Day, Year): JAN 13 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that tha death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

214-16-4100 Vernon Thomas

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41499

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Esther Corrine Yorker

2. Date of Death — Month: December Day: 22 Year: 1997

3. Time of Death: 1815

4a. Facility Name *(If not institution, give street and number)*: Kent & Queen Anne's Hospital

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 215-20-0255

6. Sex: 1☐ M 2☒ F

7. Age *(In yrs. last birthday)*: 72 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: 04-26-1925

9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: maryland

10b. County: Kent

10c. City, Town or Location: chestertown

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 345 Cannon Street

10f. Zip Code: 21620

10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 10th — College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Domestic

16b. Kind of Business/Industry: Private Family

17. Father's Name *(First, Middle, Last)*: Leonard A. Hodges

18. Mother's Name *(First, Middle, Maiden Surname)*: Jearline Cisco

19a. Informant's Name/Relationship *(Type, Print)*: Betty Rowe (daughter)

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 345 Cannon Street, Chestertown, Maryland 21620

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Pomona Cemetery — Date: 1/3/1998

20c. Location - City or Town, State: Chestertown, Maryland

21. Signature of Funeral Service Licensee: John A. Prince

22. Name and Address of Facility: Bennie Smith Funeral Home, P.O.Box 1687, Easton, Maryland 21601

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): e. CVA — 2days

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: CHF, Cardiomyopathy, Cirrhosis, COPD

23b. **Did tobacco use contribute to the cause of death?** 1☒ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: C. Bauman

29c. License number: D00 354

29d. Date signed *(Month, Day, Year)*: 12/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): C.A. BAUMANN 100 BROWN ST. CHESTERTOWN, Md 21620

State Registrar

31. Date filed *(Month, Day, Year)*: JAN 06 1998

32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 41500

Items: 23 part I,25,27,28a-f per MEO G-756 2/5/98 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Deta of Death Month / Dey / Yeer	3. Time of Death
Edward G. Bates	Nov. 28,1997	12:55 p.m.

4a. Facility Nema (If not institution, giva street and number)	4b. City, Town, or Location of Death	4c. County of Death
Genesis Elder Care/ Perring Parkway	Parkville	Baltimore

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Yaar: Months / Deys	If Under 24 Hrs.: Hours / Min.	8. Dete of Birth (Month, Dey, Yeer)	9. Birthplaca (Stete or Foreign Country)
576-88-1343	1[X] M 2[ ] F	36 Yrs.			Dec. 29,1960	Balto.,Md.

Usual Residenca of Decedent

10e. Stete	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Baltimore	Dundalk	1[ ] Yas 2[X] No

10e. Street end Number	10f. Zip Code	10g. Citizen of What Country?
3446 McShaneway	21222	U.S.A.

11. Marital Status	12. Was Decedant Ever in U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.)	14. Raca - Amarican Indian, Black, White, atc.
1[X] Nevar Married 2[ ] Married 3[ ] Widowed 4[ ] Divorced	1[ ] Yas 2[X] No If Yes, Give Yaar or Dates:	1[ ] Yes 2[X] No Specify:	Specify: WHite

15. Decedent's Education (Specify only highest grade completed)		16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementery/Secondary (0-12)	College (1-4or 5+)		
10		Laborer	Roadwork

17. Fethar's Name (First, Middle, Last)	18. Mother's Neme (First, Middle, Meiden Sumame)
Edward G. Bates	Sandra Downes

19e. Informant's Name/Reletionship (Type, Print)	19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)
Sandra Downes	3446 McSHaneway Dundalk, Md. 21222

20e. Method of Disposition	20b. Piece of Disposition (Neme of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, Stete
1[X] Buriel 2[ ] Cremetion 3[ ] Removal from Stete 4[ ] Donetion 5[ ] Othar (Specify)	OakLawn Cemetery	12-2-97	Baltimore, Maryland

21. Signeture of Funeral Service Licensee: Bernard Dabrowski

22. Name end Address of Facility: Bradley-Ashton-Dabrowski-Matthews Funeral Home, Inc 2134 Willow Spring Rd., Dundalk, Maryland 21222

#93 #

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one ceuse on each line.

Approximete Intervel Between Onset and Death

Immediete Cause (Final disaese or condition resulting in death): e. MULTIPLE INJURIES WITH COMPLICATIONS Traumatic brain injury

Due to (or es a consequence of): fever

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest:

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1[ ] Yes 2[X] No 3[ ] Probably 4[ ] Unknown

24e. Wes en autopsy performed?	24b. Were autopsy findings eveilebla prior to completion of causa of deeth?
1[ ] Yes 2[X] No	1[ ] Yes 2[ ] No

25. Wes case referred to medical examiner?	26. Piece of Deeth (Check only ona)	
1[X] Yes 2[X] No	Hospitel: 1[ ] Inpetient 2[ ] ER/Outpetient 3[ ] DOA	Other: 4[X] Nursing Home 5[ ] Residence 6[ ] Other (Specify)

27. Menner of Deeth	28e. Dete of Injury (Month, Dey Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1[X] Natural 2[X] Accident 3[ ] Suicide 4[ ] Homicide 5[ ] Pending Investigetion 6[ ] Could not be determined	12/1/96	Unknown M	1[ ] Yes 2[X] No	Pedestrian struck by auto

28a. Placa of Injury - At home, ferm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stete)
Highway	I-95 New Jersey

29a. Certifier (Check only one): 1[X] **Certifying Physician**: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and manner es steted. 2[ ] **Medical Exeminer**: On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner steted.

29b. Signetura and title of certifier	29c. Licensa number	29d. Data signed (Month, Dey, Yeer)
	D41901	12/1/97

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Dr. Ziad K. Mirza 3007 E. Northern Pkwy, Baltimore, MD 21214

State Registrar

31. Date filed (Month, Dey, Yeer)	32. Registrar's Signature
FEB 05 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41501

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Mary Elizabeth Byrd
2. Date of Death: Month 12 Day 1 Year 97
3. Time of Death: 00.35
4a. Facility Name (If not institution, give street and number): Harford Memorial Hospital
4b. City, Town, or Location of Death: Havre de Grace
4c. County of Death: Harford

Funeral Director

5. Social Security Number: 215 12 1576
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 87 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): Nov. 6, 1910
9. Birthplace (State or Foreign Country): South Carolin

Usual Residence of Decedent

10a. State: MD
10b. County: Harford
10c. City, Town or Location: Havre de Grace, Maryland
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 107 George Court
10f. Zip Code: 21078
10g. Citizan of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorcad
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Giva Yaar or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yas or No- if Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 5 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housekeeper
16b. Kind of Business/Industry: Domestic

17. Father's Name (First, Middle, Last): Benjamin Byrd
18. Mother's Name (First, Middle, Maiden Surneme): Mary Elizabeth Wright

19a. Informant's Name/Relationship (Type, Print): Harrison Byrd, Jr. Son
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 105 Garfield Court, Havre de Grace, Md. 21078

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Neme of cemetery, crematory or other place): St. James Cemetery
Date: 12/6/97
20c. Location - City or Town, State: Havre de Grace, Md

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Beard Funeral Home 21078, 552 Lewis Street, Havre de Grace, Md.

Physician /Medical Examiner

23a. Part i. Enter the disease, or complications that caused the death. Do not entar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Ceuse (Final diseasa or condition resulting in deeth) a.	Septic Shock / Hypotension	1 week
Due to (or as a consequenca of): b.	Cardiac failuse.	1 week
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last — Due to (or as a consequence of): c.	Coagulopathy	1 week
Due to (or as a consequence of): d.	Dehydration	1 week

Part ii. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Chronic Renal Failuse; Hypothyroidism; Anemia

23b. Did tobacco usa contributa to the causa of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was en autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of causa of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Plece of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician**: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature] MIRZA ABAG MD
29c. License number: D43115
29d. Date signed (Month, Day, Year): 12-1-97

30. Name end address of person who completed cause of death (Item 23a) (Type, Print): 615, S. Union Ave, Havre De Grace, Maryland

State Registrar

31. Date filed (Month, Day, Year): JAN 27 1998
32. Registar's Signeture: [signature]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours eftar death with the Maryland Department of Health and Mental Hygiena.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the **Hospital or Attending Physician**: The law requires that the death certificate be executed within 24 hours eftar death.
To the **Funeral Director**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Byrd, Mary Elizabeth December 1, 1997 0035dm

97 41502

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Female DAVIS		2. DATE OF DEATH: MONTH 9 DAY 14 YEAR 97	3. TIME OF DEATH: 1:21A M
4. SOCIAL SECURITY NUMBER: None	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): YRS.	IF UNDER 1 YEAR: MONTHS — DAYS 2; IF UNDER 24 HRS.: HOURS 19, MIN. 44
7. DATE OF BIRTH (Month, Day, Year): 9 11 97	8. BIRTHPLACE (State or Foreign Country): Maryland		
8a. FACILITY NAME (If not institution, give street and number): Prince Georges Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly	9c. COUNTY OF DEATH: Prince Georges	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery County	10c. CITY, TOWN OR LOCATION: ADelphi	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1822 Mezerott Road	10f. ZIP CODE: 20783	10g. CITIZEN OF WHAT COUNTRY?: U.S.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Infant	16b. KIND OF BUSINESS/INDUSTRY: Infant	
17. FATHER'S NAME (First, Middle, Last): Unknown	18. MOTHER'S NAME (First, Middle, Maiden Surname): Arlene DAVIS		
19a. INFORMANT'S NAME (Type/Print): Arlene DAVIS	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1822 Mezerott Road ADelphi md 20783		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MEDEXPRESS HAM ROAD NC	DATE	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Pfafe Church MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Extreme Prematurity	
OUE TO (OR AS A CONSEQUENCE OF): b.	Pulmonary Insufficiency	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — OUE TO (OR AS A CONSEQUENCE OF): c.	Pulmonary Hemorrhage	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Antoine K. Formad MD	29c. LICENSE NUMBER: D16239	29d. DATE SIGNED (Month, Day, Year): 2/6/98

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 30001 Hospital Drive, Cheverly Md.

31. DATE FILED (Month, Day, Year): 2/6 FEB 12 1998	32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

KB

OHMH-16 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #7, 1/12/98, C.C., Kent County — *Certificate of Death* — Reg. No. 97 41503

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Philip Butler Sherman Davis, Sr.

2. Deta of Deeth — Month: December; Day: 25; Yaar: 1997

3. Time of Deeth: 0115

4a. Facility Nema *(If not institution, giva straat and number)*: Union Hospital of Elkton

4b. City, Town, or Location of Daath: Elkton

4c. County of Deeth: Cecil

Funeral Director

5. Social Security Numbar: 217-12-9539

6. Sax: 1☒ M 2☐ F

7. Aga *(In yrs. last birthday)*: 74 Yrs.

If Undar 1 Year — Months: ; Deys:

If Under 24 Hrs. — Hours: ; Min.:

8. Deta of Birth *(Month, Day, Yaar)*: June 10, 1923

9. Birthplaca *(Stata or Foraign Country)*: Maryland

Usual Residence of Dacadant

10a. Stata: Maryland

10b. County: Cecil

10c. City, Town or Location: 496 N. St. Augustine Road, Elkton

10d. Insida City Limits: 1☐ Yas 2☒ No

10e. Street end Numbar: 496 N. St. Augustine Road

10f. Zip Coda: 21915

10g. Citizan of What Country?: U.S.A.

11. Marital Status: 1☐ Navar Married 2☐ Married 3☒ Widowad 4☐ Divorcad

12. Was Decedent Ever in U.S. Armed Forcas? 1☐ Yas 2☒ No — If Yas, Giva Yeer or Datas:

13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 1☐ Yas 2☒ No *Specify:*

14. Race - Amaricen Indian, Black, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highast grada complatad)*: Elamantary/Secondary (0-12): 3; Collaga (1-4or 5+):

16a. Decedent's Usual Occupation *(Giva kind of work dona during most of working life. DO NOT use retired)*: Carpenter/ Truck Driver

16b. Kind of Businass/Industry: Construction/ Retail Milk Distributor

17. Fathar's Name *(First, Middla, Last)*: William Davis

18. Mothar's Name *(First, Middla, Maiden Surname)*: Unknown

19a. Intormant's Name/Raletionship *(Type, Print)*: Andrew Paraq/Nephew

19b. Mailing Address *(Straat and Numbar or Rural Routa Numbar, City or Town, State, Zip Coda)*: 2226 Seeneytown Road, Dover, Delaware 19904

20a. Mathod of Disposition: 1☒ Burial 2☐ Cramation 3☐ Ramoval from Stata 4☐ Donation 5☐ Othar *(Specify)*

20b. Placa of Disposition *(Nama of cematary, cramatory or other place)*: Bethel Cemetery/December 28, 1997 — Data:

20c. Location - City or Town, Stata: Chesapeake City, Maryland

21. Signature of Funaral Sarvice Licansaa: Gary B. Fellows

22. Nama and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 226 E. Main Street, Cecilton, Maryland 21913

Physician /Medical Examiner

23a. Part1. Entar the diseese, or complicetions thet ceusad tha daath. Do not entar tha moda of dying, such as cerdiac or raspiretory arrast, shock, or haart failura. List only ona causa on aach lina.

Approxtmate Intarval Batwaan Onset and Death

Immediete Cause (Finel disaase or condition resulting in daath)
a. Sepsis — 2 wks.

Dua to (or as a consequence of):
b. Cellulitis / ulceration / gangrene bilateral legs — 6 months

Saquantially list conditions, if any, leading to immadiate causa. Entar Underlying Ceusa (Disaase or Injury that initiated avants resulting in daath) Last
Dua to (or as a consequance of):
c. Peripheral vascular insufficiency — > several years
Dua to (or as a consequance of):
d. Aortic Stenosis severe — > several years

Part II. **Other significant conditions** contributing to death but not resulting in tha underlying ceuse given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Wes an autopsy performad? 1☐ Yas 2☒ No

24b. Were autopsy findings available prior to completion of ceuse of death? 1☐ Yas 2☐ No

25. Was case referred to medical examiner? 1☐ Yas 2☒ No

26. Place of Death *(Check only ona)*: Hospital: 1☒ Inpatiant 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residance 8☐ Othar *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding Investigation 6☐ Could not be determined

28a. Data of Injury *(Month, Day Yaar)*

28b. Tima of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At homa, ferm, straat, factory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Routa Number, City or Town, State)*

29a. Cartifiar *(Check only one)*: 1☒ **Certifying Phyaician:** To tha bast of my knowledge, deeth occurred at tha time, dete end plece, and dua to the cause(s) end menner as steted. 2☐ **Medical Examiner:** On the basis of exemination and/or investigation, in my opinion, daeth occurred at the time, date and place, and dua to tha ceuse(s) and mannar stated.

29b. Signature end titla of certifiar: Cecilia B. Calderon MD

29c. License number: D37916

29d. Data signed *(Month, Day, Yaar)*: 12.28.97

30. Name and address of person who completed ceusa of death (Item 23a) (Type, Print): Cecilia B. Calderon, MD, 223 W. Main Street, Elkton, Maryland 21921

State Registrar

31. Data filed *(Month, Day, Yaar)*: JAN 06 '98

32. Registrar's Signatura: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: Tha law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Davis, Philip

10

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Item:7 per FH G-757 3/6/98 dh
Item:1 per MD G-757 3/6/98 dh

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41504

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): VERA HALL ~~Gilmore~~ Gillmore
2. Date of Death (Month, Day, Year): Nov 21, 1997
3. Time of Death: 4:20 PM

4a. Facility Name (If not institution, give street and number): Holy Cross Hospital
4b. City, Town, or Location of Death: Silver Spring
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 218 56 8987
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): ~~77~~ 94 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Mar 28 1902
9. Birthplace (State or Foreign Country): Ohio

Usual Residence of Decedent

10a. State: Md
10b. County: Montgomery
10c. City, Town or Location: Wheaton
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 11901 Georgia Avenue
10f. Zip Code: 20902
10g. Citizen of What Country?: USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Housewife
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Lemuel Ream
18. Mother's Name (First, Middle, Maiden Surname): ALice (Unknown)

19a. Informant's Name/Relationship (Type, Print): Susannah Hall Roberts
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4704 Clyde Ave., Box 124, Garrett Park, Md 20896

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): George Washington Med. Ctr. Date: Nov 22 1997
20c. Location - City or Town, State: Washington DC

21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: Columbia Mortuary, 9013 Annapolis Rd, Lanham, Md 20706

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Gastrointestinal Bleed — 24 Hours.
Due to (or as a consequence of):
b. Ruptured Viscera.
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Sepsis
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]
29c. License number: D43496
29d. Date signed (Month, Day, Year): 11-22-97.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Mohammad A Khaled MD 8830-Cameron Court Suit 502 Silver Spring 20910

State Registrar

31. Date filed (Month, Day, Year): FEB 06 1998
32. Registrar's Signature: Julia Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41505

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Baby Boy Goldstein
2. Date of Death: Month: November; Day: 26; Year: 1997
3. Time of Death: 10:55pm
4a. Facility Name *(If not institution, give street and number)*: Sinai Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: N|A
6. Sex: [X] 1 M 2 F
7. Age *(In yrs. last birthday)*: 0 Yrs.
If Under 1 Year: Months: 0; Days: 0
If Under 24 Hrs.: Hours: 0; Min.: 26
8. Date of Birth *(Month, Day, Year)*: Nov. 26, 1997
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Baltimore
10c. City, Town or Location:
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 8829 Margate Court
10f. Zip Code: 21208
10g. Citizen of What Country?: N|A

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 1 [X] Yes 2 [ ] No Specify: CHILIAN
14. Race - Americen Indian, Black, White, etc. Specify: White

15. Decedent's Education *(Specify only highest grade completed)*: Elamentary/Secondary (0-12): N|A; College (1-4or 5+): N|A
16a. Decedent's Usual Occupation *(Giva kind of work done during most of working life. DO NOT use retired)*: N|A
16b. Kind of Business/Industry: N|A

17. Father's Name *(First, Middle, Last)*: David Michael Goldstein
18. Mother's Name *(First, Middle, Meiden Sumeme)*: Paula Andrea Viedma

19a. Informant's Name/Relationship *(Type, Print)*: Paula Goldstein | mother
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, Stete, Zip Code)*: 8829 Margate Ct. Balto., MD 21208

20a. Mathod of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, cremetory or other piece)*: Sinai Hospital
Dete: Nov.26,1997
20c. Location - City or Town, State: Balto., MD

21. Signature of Funeral Service Licensee: PAID - FACILITIES
22. Name and Address of Facility: 2401 W. BELVEDERE AVE SINAI 1402P

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such es cerdiac or raspiratory arrast, shock, or heart failure. List only one ceuse on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disaasa or condition rasulting in death): a. Severe immaturity
Due to (or as a consaquence of):
Sequentially list conditions, if any, leading to immediate ceusa. Enter Underlying Cause (Disaase or injury that initiated events rasulting in death) Last
b.
Due to (or as a consequence of):
c.
Dua to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying ceuse givan in Part I.

23b. Did tobacco use contribute to the causa of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of ceusa of daath? 1 [ ] Yes 2 [X] No

25. Was cese referred to medical examiner? 1 [ ] Yas 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Mannar of Death: 1 [X] Natural 2 [ ] Accidant 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Dey Year)*: N|A
28b. Tima of Injury: M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: N|A
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*: N|A
28f. Location *(Street end Number or Rurel Route Number, City or Town, State)*: N|A

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician**: To the best of my knowledge, daath occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 [ ] **Medical Examinar**: On tha basis of axamination and/or investigation, in my opinion, death occurred at tha tima, data and place, and dua to the cause(s) and manner stated.
29b. Signature and title of certifier: Mary Ann Sorra
29c. License number: AS2402321NS9298
29d. Date signed *(Month, Dey, Year)*: Nov. 27, 1997

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print): Mary Ann Sorra, M.D. 2401 W. Belvedere Ave. Balto., MD 21215

State Registrar

31. Date filed *(Month, Dey, Yeer)*: FEB 06 1998
32. Registrar's Signature: Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pagas 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41506

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DAVID HOLMAN
2. Date of Death Month / Day / Year: Nov 20 1997
3. Time of Death: 4:40 AM
4a. Facility Name *(If not institution, give street and number)*: ST AGNES HEALTH CARE
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: NONE
6. Sex: 1 ☑ M 2 ☐ F
7. Age *(In yrs. last birthday)*: 0 Yrs. — If Under 1 Yaar: Months / Days — If Under 24 Hrs.: Hours 3 / Min. 41
8. Date of Birth *(Month, Day, Year)*: NOV. 20, 1997
9. Birthplace *(State or Foreign Country)*: MD.

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: BALTIMORE
10d. Inside City Limits: 1 ☑ Yes 2 ☐ No
10e. Street and Number: 3000 HOLLINS FERRY Rd. Apt 3
10f. Zip Code: 21230
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): N/A — College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: N/A
16b. Kind of Business/Industry: NONE

17. Father's Name *(First, Middle, Last)*: MICHAEL HOLMAN
18. Mother's Name *(First, Middle, Maiden Surname)*: EVA MAE BODDIE

19a. Informant's Name/Relationship *(Type, Print)*: ST. AGNES HOSP.
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 900 S. CATON AVE 21229

20a. Method of Disposition: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: St Agnes Hosp. — Date: 11-20-97
20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: Cathy Berg /per R. Colyer
22. Name and Address of Facility: St. Agnes Hospital / 900 S. Caton Ave, Baltimore, MD 21229

Physician /Medical Examiner

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. PRE-VIABILITY

Due to (or as a consequence of): b. IMMATURITY

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or as a consequence of): c. PREMATURE BIRTH

Due to (or as a consequence of): d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

26. Place of Death *(Check only one)*: Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other *(Specify)*

27. Manner of Death: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 ☐ Yes 2 ☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 ☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: A G Santos MD NEONATOLOGIST
29c. License number: D14955
29d. Date signed *(Month, Day, Year)*: 1/30/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): ARTURO G. SANTOS, MD. 900 CATON AVE BALTIMORE, MD 21229

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 18 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

NAME:

K.B

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41507

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month Day Year	3. Time of Death
JARED	ROBERT	LAKE	MAY 15, 1997	10:23AM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SAINT JOSEPH MEDICAL CENTER	TOWSON	BALTIMORE

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
0	1☒M 2☐F	Yrs.			5 MAY 15, 1997	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Md.	Harford	Bel Air	1☐Yes 2☒No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
803 Majors Choice Drive	21014	United States

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒Never Married 2☐Married 3☐Widowed 4☐Divorced	1☐Yes 2☒No If Yes, Give Year or Dates:	1☐Yes 2☒No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0	0	0	0

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Sumame)
William Robert Lake	Alesia Lee Dipietro

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Alesia Lee Lake (Mother)	803 Majors Choice Drive, Bel Air, Md. 21014

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)	Holy Redeemer	10/97	Baltimore

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	7620 York Road St. Joseph Medical Center Towson, Md.

Physician /Medical Examiner

23a. Part I. Enter the disease, or compilcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. EXTREME PREMATURITY (INFANT NOT VIABLE)	5 MINS.
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. PROM - PRETERM LABOR	
	Due to (or as a consequenca of):	
	c. CHORIOAMNIONITIS	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☒No 3☐Probably 4☐Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐Yes 2☒No	1☐Yes 2☒No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)
1☐Yes 2☒No	Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒Naturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined		M	1☐Yes 2☐No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one)
1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ Marilyn Bennett MD.	D 27352	2-9-98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
MARILYN BENNETT, M.D., 7620 YORK ROAD, TOWSON, MARYLAND 21204

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 12 1998	▶ Julie Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items:24a,27,29a per MD G-756 2/6/98 dh

Certificate of Death

97 41508
Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ENRIQUE MUNGUIA
2. Date of Death (Month, Day, Year): December 31, 1997
3. Time of Death: 2:21pm
4a. Facility Name (If not institution, give street and number): WASHINGTON ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: TAKOMA PARK
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 216-19-7529
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 65 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): AUG. 10 32
9. Birthplace (State or Foreign Country): MANAGUA

Usual Residence of Decedent

10a. State: MD
10b. County: MONTGOMERY
10c. City, Town or Location: ROCKVILLE
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4805 EADES STREET
10f. Zip Code: 20853
10g. Citizen of What Country?: MANAGUA

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [X] Yes 2 [ ] No Specify:
14. Race - American Indian, Black, White, etc. Specify: HISPANIC

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 6TH; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): UNEMPLOYED
16b. Kind of Business/Industry: NONE

17. Father's Name (First, Middle, Last): PEDRO JUADALUPE SOLIZ
18. Mother's Name (First, Middle, Maiden Surname): MARGUEZA MUNGUIA

19a. Informant's Name/Relationship (Type, Print): PRESTON MUNGUIA -SON
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4805 EADES STREET ROCKVILLE, MARYLAND 20853

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): NORBECK MEMORIAL PARK
Date: JAN 3 98
20c. Location - City or Town, State: ONLEY, MARYLAND

21. Signature of Funeral Service Licensee: W.H. Bacon 276
22. Name and Address of Facility: W.H. BACON FUNERAL HOME INC. 3447 14TH STREET, NW WASHINGTON, D.C. 20010

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. REDO CORONARY BYPASS — HOURS

Due to (or as a consequence of):
b. CORONARY HEART DISEASE WITH UNSTABLE ANGINA — WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Thomas Militano MD
29c. License number: D36207
29d. Date signed (Month, Day, Year): December 31, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DR. THOMAS MILITANO, 7610 CARROLL AVE, TAKOMA PARK, MD 20912

State Registrar

31. Date filed (Month, Day, Year): FEB 06 1998
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41509

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Baby Boy of Katerina Neuhauser
2. Date of Death: Month 12 Day 7 Year 97
3. Time of Death: 23:41
4a. Facility Name (If not institution, give street and number): JOHNS HOPKINS HOSPITAL
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death:

Funeral Director

5. Social Security Number: NONE
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min. 1
8. Date of Birth (Month, Day, Year): 12-7-97
9. Birthplace (State or Foreign Country): MARYLAND

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: BELTSVILLE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 4501 GARRETT AVENUE
10f. Zip Code: 20705
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0 | College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): INFANT
16b. Kind of Business/Industry: INFANT

17. Father's Name (First, Middle, Last): THOMAS NEUHAUSER
18. Mother's Name (First, Middle, Maiden Surname): KATERINA THANATOULOU

19a. Informant's Name/Relationship (Type, Print): KATERINA NEUHAUSER/MOTHER
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4501 GARRETT AVENUE, BELTSVILLE, MARYLAND 20705

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) DISPOSAL
20b. Place of Disposition (Name of cemetery, crematory or other place): JOHNS HOPKINS HOSPITAL
Date: 12-8-97
20c. Location - City or Town, State: BALTIMORE, Maryland

21. Signature of Funeral Service Licensee: Raymond Johnson
22. Name and Address of Facility: 600 N.WOLFE STREET, BALTIMORE, MARYLAND21287

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. lethal thanatophoric dwarfism — 1 min

Due to (or as a consequence of):
b. skeletal dysplasia — 1 min

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
extreme prematurity
genetic termination of pregnancy

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D0052071
29d. Date signed (Month, Day, Year): 12/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edith Gurewitsch, M.D. 601 North Wolfe St. Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year): FEB 06 1998
32. Registrar's Signature: Richardson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

97 41510

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physican and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DARRIN Jamal Neely			2. DATE OF DEATH (Month / Day / Year): 10 / 1 / 97	3. TIME OF DEATH: 1228 A M
4. SOCIAL SECURITY NUMBER: INfant	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.: 5	7. DATE OF BIRTH (Month, Day, Year): 10 1 97	8. BIRTHPLACE (State or Foreign Country): maryland
9a. FACILITY NAME (If not institution, give street and number): Prince Georges Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly		9c. COUNTY OF DEATH: prince Georges

RESIDENCE OF DECEDENT

10a. STATE: md	10b. COUNTY: prince Georges	10c. CITY, TOWN OR LOCATION: TAKOMA PARK	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 7403 Hancock Avenue 202		10f. ZIP CODE: 20912	10g. CITIZEN OF WHAT COUNTRY?: US

11. MARITAL STATUS: INfant (1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced)	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: INfant	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): INfant; College (1-4 or 5+): INfant	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): INfant	16b. KIND OF BUSINESS/INDUSTRY: INfant	
17. FATHER'S NAME (First, Middle, Last): Unknown		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nicole Neely	
19a. INFORMANT'S NAME (Type/Print): Nicole Neely	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7403 Hancock Avenue #202 Takoma Park 20912		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify): Unassembly	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): PG Hospital — DATE: 10/3/97	20c. LOCATION — City or Town, State: Cheverly MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: PGHC, Cheverly MD 20785		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Prematurity	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☑

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☑ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Emmanuel Atiemo, MD	29c. LICENSE NUMBER: D22924	29d. DATE SIGNED (Month, Day, Year): 10 . 1 . 97
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Emmanuel ATiemo P.G. Hospital		
31. DATE FILED (Month, Day, Year): FEB 06 1998	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41511

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Baby Girl PAGE
2. Date of Death Month / Day / Year: 09 - 18 - 97
3. Time of Death: 5:35 PM
4a. Facility Name *(If not institution, give street and number)*: Prince Georges Hospital C
4b. City, Town, or Location of Death: Cheverly
4c. County of Death: Prince Georges

Funeral Director

5. Social Security Number: INFANT
6. Sex: 1☐ M 2☑ F
7. Age *(In yrs. last birthday)* Yrs.: If Under 1 Year Months / Days: 4; If Under 24 Hrs. Hours / Min.:
8. Date of Birth *(Month, Day, Year)*: 09-14-97
9. Birthplace *(State or Foreign Country)*: Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Prince Georges
10c. City, Town or Location: Capitol Heights
10d. Inside City Limits: 1☑ Yes 2☐ No
10e. Street and Number: 332 Carmody Hills Ave
10f. Zip Code: 20743
10g. Citizen of What Country?

11. Marital Status: INFANT — 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☐ No If Yes, Give Year or Dates: INFANT
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☑ No Specify:
14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): INFANT; College (1-4or 5+): INFANT
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: INFANT
16b. Kind of Business/Industry: INFANT

17. Father's Name *(First, Middle, Last)*: Kenneth Page
18. Mother's Name *(First, Middle, Maiden Surname)*: Francine PAGE

19a. Interment's Name/Relationship *(Type, Print)*: (Mother) Francine PAGE
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 332 Carmody Hills Avenue Capitol Height 20743
20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☑ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MEDEX — Date: 3497
20c. Location - City or Town, State: Hanover MD
21. Signature of Funeral Service Licensee: [signature]
22. Name and Address of Facility: PGHC Cheverly MD 20785

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death):
e. Recurrent Pneumothoraces, (Right)
Due to (or as a consequence of):
b. Prematurity
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Respiratory Distress Syndrome
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Hypotension; Atelectasis, Right lung; Metabolic acidosis; Anemia

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☑ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death *(Check only one)*: Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier *(Check only one)*: 1☐ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature], MD
29c. License number: D27628
29d. Date signed *(Month, Day, Year)*: 9-18-97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Isabelita G. Frattarola — Prince Georges Hospital Center Cheverly, Maryland.

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 12 1998
32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

K-B

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41512

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Patricia Diane Stenger

2. Dete of Deeth — Month: December; Dey: 30; Yeer: 1997

3. Time of Deeth: 1837

4e. Fecility Neme (If not institution, give street end number): Kent & Queen Anne's Hospital

4b. City, Town, or Location of Deeth: Chestertown

4c. County of Death: Kent

Funeral Director

5. Sociel Security Number: 218-72-2042

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthdey): 35 Yrs. — If Under 1 Year: Months / Deys; If Under 24 Hrs.: Hours / Min.

8. Dete of Birth (Month, Dey, Yeer): May 2, 1962

9. Birthplece (State or Foreign Country): Maryland

Usuel Residence of Decedent

10e. Stete: Maryland

10b. County: Kent

10c. City, Town or Locetion: Chestertown

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street end Number: 23160 Baywood Court, Apt. 18A

10f. Zip Code: 21620

10g. Citizen of Whet Country?: U.S.A.

11. Marital Status: 1☐ Never Merried 2☒ Married 3☐ Widowed 4☐ Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:

13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Rece - American Indien, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementery/Secondery (0-12): 12; College (1-4or 5+):

16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Sales Clerk

16b. Kind of Business/Industry: Retail Hardware

17. Fether's Neme (First, Middle, Last): Buddy Batchelor

18. Mother's Neme (First, Middle, Meiden Surneme): Alice Palmatary

19e. Informent's Neme/Reletionship (Type, Print): David M. Stenger/Husband

19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code): 23160 Baywood Court, Apt. 18A, Chestertown, Maryland 21620

20e. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removel from State 4☐ Donation 5☐ Other (Specify)

20b. Plece of Disposition (Neme of cemetery, cremetory or other piece): Chesapeake Cremation Center, LLC/

Dete: January 1, 1998

20c. Locetion - City or Town, Stete: Stevensville, Maryland

21. Signeture of Funeral Service Licensee: ▶ Kirk S. Helfenbein

22. Neme end Address of Fecility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 130 Speer Road, Chestertown, Maryland 21620

Physician /Medical Examiner

23e. Pert I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heart failure. List only one ceuse on eech line.

		Approximete Interval Between Onset end Deeth
Immediete Ceuse (Finel diseese or condition resulting in deeth)	e. Extensive Bilateral Pneumonia	1 week
	Due to (or es e consequence of):	
Sequentiellty list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury thet initieted events resulting in deeth) Last	b.	
	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.: (1) Diabetes Mellitus (2) asthma (3) Hypertension (4) Inflammatory arthritis (5) History of colitis (6) Morbid obesity

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Wes en autopsy performed? 1☑ Yes 2☐ No

24b. Were autopsy findings evelieble prior to completion of cause of death? 1☑ Yes 2☐ No

25. Wes case referred to medical exeminer? 1☐ Yes 2☑ No

26. Plece of Deeth (Check only one): Hospital: 1☑ Inpetient 2☐ ER/Outpetient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Deeth: 1☑ Neturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28e. Dete of Injury (Month, Dey Yeer)

28b. Time of Injury M

28c. Injury et Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify)

28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. 2☐ **Medical Examiner:** On the basis of exeminetion end/or investigetion, in my opinion, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner steted.

29b. Signeture end title of certifier: ▶ K.K. Wun, MD.

29c. License number: D21313

29d. Dete signed (Month, Dey, Yeer): 1/1/98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): KIN K. WUN, 223 High St., Chestertown, MD 21620

State Registrar

31. Dete filed (Month, Dey, Yeer): JAN 02 '98

32. Registrer's Signeture: ▶ Julia Davidson-Randell

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

4

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item: 24a Per T.W. Film G-756 2-12-98RC

Certificate of Death

Reg. No. 97 41513

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Aaron Smithwiggin

2. Date of Death — Month: 11 Day: 30 Year: 97

3. Time of Death: 18:10

4a. Facility Name (If not institution, give street and number): UMMS

4b. City, Town, or Location of Death: Baltimore

4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: none

6. Sex: 1☑ M 2☐ F

7. Age (In yrs. last birthday) Yrs.: If Under 1 Year — Months: Days: If Under 24 Hrs. — Hours: 3 Min.: 33

8. Date of Birth (Month, Day, Year): 11/30/97

9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10e. State: Maryland

10b. County: Baltimore City

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 615 St. Stevens Street

10f. Zip Code: 21216

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 0 College (1-4or 5+): 0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): none - infant

16b. Kind of Business/Industry: none

17. Father's Name (First, Middle, Last): unknown

18. Mother's Name (First, Middle, Maiden Surname): Virginia Smithwiggins

19a. Informant's Name/Relationship (Type, Print): Virginia Smithwiggins

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 615 St. Stevens St., Baltimore, Maryland 21216

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify) In state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director — 12/12/97

22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	respiratory failure	3hr 33min
Due to (or as a consequence of): b.	Sepsis	3hr 33min
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	extreme prematurity	3hr 33min
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one) — Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☑ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Rose Marie Viscardi MD

29c. License number: D3775

29d. Date signed (Month, Day, Year): 11/30/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Rose Marie Viscardi MD 22 S. Greene St. Baltimore MD 21201

State Registrar

31. Date filed (Month, Day, Year): FEB 12 1998

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

97 41514

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Angel Janette Wilson
2. DATE OF DEATH — MONTH: 11 DAY: 19 YEAR: 97
3. TIME OF DEATH: 11 28p M
4. SOCIAL SECURITY NUMBER: INFant
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday) YRS.: IF UNDER 1 YEAR — MONTHS: DAYS: IF UNDER 24 HRS. — HOURS: MIN.: 32
7. DATE OF BIRTH (Month, Day, Year): 11/19/97
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Prince Georges Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly
9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince Georges
10c. CITY, TOWN OR LOCATION: Lanham
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 9402 Van-Yuren street
10f. ZIP CODE: 20706
10g. CITIZEN OF WHAT COUNTRY?: U.S.
11. MARITAL STATUS: INFant — 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: INFant
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): INFant — College (1-4 or 5+): INFant
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): INFant
16b. KIND OF BUSINESS/INDUSTRY: INFant
17. FATHER'S NAME (First, Middle, Last): James DAVID Wilson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Antionette Hargrove
19a. INFORMANT'S NAME (Type/Print): antionette Hargrove
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9402 Van-Yuren Street Lanham md 20706
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify): Autopsy
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Place — DATE: 1-30-98
20c. LOCATION — City or Town, State: Cheverly MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Place Cheverly MD 20785

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Extreme Prematurity (22-23 weeks gestation)
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature], M.D.
29c. LICENSE NUMBER: D27628
29d. DATE SIGNED (Month, Day, Year) ▶ 1-28-98
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Isabelita G. Frattarola, M.D. Prince Georges Hospital Center Cheverly, Maryland
31. DATE FILED (Month, Day, Year): FEB 06 1998
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

K.B.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41515

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anna Pauline Wallace

2. Date of Death — Month: December Day: 31 Year: 1997

3. Time of Death: 1843

4a. Facility Name (If not institution, give street and number): Kent & Queen Anne's Hospital

4b. City, Town, or Location of Death: Chestertown

4c. County of Death: Kent

Funeral Director

5. Social Security Number: 212-76-6491

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 86 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): July 1, 1911

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland

10b. County: Kent

10c. City, Town or Location: Millington

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 417 E. Cypress Street

10f. Zip Code: 21651

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Bieck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 11 — College (1-4or 5+):

16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Domestic/Own Home

17. Father's Name (First, Middle, Last): Alfred Robinson

18. Mother's Name (First, Middle, Meldan Surnema): Julia Elizabeth Dixon

19a. Informent's Name/Relationship (Type, Print): Thelma P. Willis/Daughter

19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code): 28028 Creamery Street, Kennedyville, Maryland 21645

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cramatory or other place): Asbury Cemetery/January 3, 1998

20c. Location - City or Town, State: Millington, Maryland

21. Signature of Funerel Service Licensee: Gary B Fellows

22. Name and Address of Facility: Fellows, Helfenbein & Newnam Funeral Home, P.A. 370 W. Cypress Street, Millington, Maryland 21651

Physician /Medical Examiner

23a. Part1. Enter the diseese, or complications thet caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on eech line.

Approximate Interval Between Onset and Death

Immediete Ceuse (Finel disease or condition resulting in deeth)

e. Cardiomyopathy — years

Due to (or es e consequence of):

b. ASCVD — Years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequance of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Hepertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residance 6☐ Other (Specify)

27. Manner of Death: 1☒ Naturel 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one) 1☒ **Certifying Physician**: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end manner as stated. 2☐ **Medical Examiner**: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete end piece, end due to the cause(s) and menner stated.

29b. Signature and titia of certifier: A Baumann

29c. Licansa number: D00 3524

29d. Date signed (Month, Day, Year): 1/6/98

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print): C.E. BAUMANN 100 BROWN ST CHESTERTOWN, MD 21620

State Registrar

31. Date filed (Month, Dey, Year): JAN 06 '98

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

8

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41516

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MARGARET WILLIAMS
2. Date of Death: Month 12 Day 31 Year 97
3. Time of Death: 0619
4a. Facility Name (If not institution, give street and number): UNIVERSITY OF MARYLAND MEDICAL SYSTEM 21201 BALTIMORE, MD
4b. City, Town, or Location of Death: BALTIMORE
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 218-14-0482
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 85 Yrs. If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 30, 1912
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Kent
10c. City, Town or Location: Chestertown
10d. Inside City Limits: ☒ Yes 2☐ No
10e. Street and Number: 101 Morgnec Road, Apt. J101
10f. Zip Code: 21620
10g. Citizen of What Country? U.S.A.

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: WHITE

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12) 11; College (1-4or 5+) 2
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Postmistress
16b. Kind of Business/Industry: United States Postal Service

17. Father's Name (First, Middle, Last): John Peter Foote
18. Mother's Name (First, Middle, Maiden Surname): Amelia Halm

19a. Informant's Name/Relationship (Type, Print): Gail T. Williams/Daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21620: 101 Morgnec Road, Apt. 101J, Chestertown, Maryland

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Cremation Center LLC/ Date: January 3, 1998
20c. Location - City or Town, State: Stevensville, Maryland

21. Signature of Funeral Service Licensee: ▶ Marvin V. Williams
22. Name and Address of Facility: Marvin V. Williams Funeral Service, P. O. Box 223, Chestertown, Maryland 21620

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. RUPTURED DESCENDING THORACIC AORTIC ANEURYSM — 18 hours

Due to (or as a consequence of):
b. HYPERTENSION

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. ATHEROMATOUS VASCULAR DISEASE

Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
NODULAR SCLEROSIS OF LIVER

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ Kenneth E. Samm MD.
29c. License number: MY4647SAS2134
29d. Date signed (Month, Day, Year): 12/31/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Kenneth E. Samm, UMMS, 22 S. Greene St Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): JAN 02 '98
32. Registrar's Signature: ▶ Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

6718-031

B.K.S

CHRISTOPHER R. CLARK
Unpend # 23part 1, 27 per MEO, 12/10/97, BMW, Montg.Co.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41517

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Christopher Riggs Clark

2. Date of Death (Month, Day, Year): NOV. 20, 1997

3. Time of Death: 10:35 AM

4a. Facility Name (If not institution, give street and number): 3333 UNIVERSITY BLVD. WEST

4b. City, Town, or Location of Death: KENSINGTON

4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 529-76-3623

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 46 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): March 18, 1951

9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland

10b. County: Montgomery

10c. City, Town or Location: Kensington

10d. Inside City Limits: 1 [X] Yes 2 [ ] No

10e. Street and Number: 3333 University Boulevard West, Apt. 1003

10f. Zip Code: 20895

10g. Citizen of What Country?: United States

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Student

16b. Kind of Business/Industry: University

17. Father's Name (First, Middle, Last): Richard M. Clark

18. Mother's Name (First, Middle, Maiden Surname): Mary Riggs

19a. Informant's Name/Relationship (Type, Print): Meryl F. Clark (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3333 University Boulevard West, Apt. 1003, Kensington, MD 20895

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Chesapeake Crematory

Date: 11-22-97

20c. Location - City or Town, State: Beltsville, Maryland

21. Signature of Funeral Service Licensee: Mark C. Villella

22. Name and Address of Facility: Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, Maryland 20910

Physician /Medical Examiner

29a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [✓] Unknown

24a. Was an autopsy performed? 1 [✓] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [✓] Yes 2 [ ] No

25. Was case referred to medical examiner? [XX] Yes 2 [ ] No

26. Place of Death (Check only one)
Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [XX] Other (Specify) IN AUTO

27. Manner of Death: 1 [XX] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. [XX] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Marjorie Bartlett

29c. License number: O.C.M.E

29d. Date signed (Month, Day, Year): NOV. 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): HALY SMITH D.KOMEN M.D. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): NOV 24 1997

32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97 41518

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Cinderella Elizabeth Kizzie
2. DATE OF DEATH (Month, Day, Year): 11 06 97
3. TIME OF DEATH: 1:00 A M
4. SOCIAL SECURITY NUMBER: None
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS 1 / MIN. 15
7. DATE OF BIRTH (Month, Day, Year): 11 6 97
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Prince Georges Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly
9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince Georges
10c. CITY, TOWN OR LOCATION: Bowie
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 506 Jones Falls Court
10f. ZIP CODE: 20721
10g. CITIZEN OF WHAT COUNTRY?: U.S.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — College (1-4 or 5 +): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): INFANT
16b. KIND OF BUSINESS/INDUSTRY: INFANT
17. FATHER'S NAME (First, Middle, Last): Timothy GAYE Kizzie
18. MOTHER'S NAME (First, Middle, Maiden Surname): Caroline Diane Gaynor
19a. INFORMANT'S NAME (Type/Print): Caroline GAYNOR
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 506 Jones Falls Court
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MEDEX — DATE 2/9/98
20c. LOCATION — City or Town, State: Mallows Bay VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: [illegible] Cheverly MD 20785

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiec or respiratory atreat, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Extreme prematurity	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☒

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Laura L. Jennings, MD ATTENDING PHYSICIAN
29c. LICENSE NUMBER: D47737
29d. DATE SIGNED (Month, Day, Year): 2/7/98
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LAURA L. JENNINGS, M.D. PRINCE GEORGES HOSPITAL CENTER 3001 HOSPITAL DRIVE, CHEVERLY
31. DATE FILED (Month, Day, Year): FEB 12 1998
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

97 41519

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alexson Pamela Nelson	2. DATE OF DEATH (Month, Day, Year): 3 6 97	3. TIME OF DEATH: 3304 M	
4. SOCIAL SECURITY NUMBER: None	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. 58	7. DATE OF BIRTH (Month, Day, Year): 3 6 97
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Prince Georges Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly	9c. COUNTY OF DEATH: Prince Georges	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Bladensburg	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 4257 58th Ave #10	10f. ZIP CODE: 20710	10g. CITIZEN OF WHAT COUNTRY?: U.S.A	
11. MARITAL STATUS: Infant (1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced)	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES: Infant	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

16. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): Infant — College (1-4 or 5+): Infant	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Infant	16b. KIND OF BUSINESS/INDUSTRY: Infant	
17. FATHER'S NAME (First, Middle, Last): Unknown	18. MOTHER'S NAME (First, Middle, Maiden Surname): Natalie Britton		
19a. INFORMANT'S NAME (Type/Print): Natalie Britton	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4257 58th Avenue #10 Bladensburg md 20710		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MEDEX — DATE: 3/10/97	20c. LOCATION — City or Town, State: WAN RIVER NC	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: PGHC 3001 Hospital Dr Cheverly		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Extreme Prematurity - Stillborn	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☑ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	26819	▶ 3/6/97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. G. CHAUDRY M.D P.G. Hospital 3001 Hospital Drive

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
FEB 12 1998	Julia Davidson-Randall

KB

DHMH-16 Rev 1/89

Remains not found:
Court order issued by:
Judge John W. Sause Jr.
Circuit Court Queen Anne's Co. Case #5740

Items# 11,12,15,16a FilmG756 2/17/98 kam
2/17/98 kam
FilmG756

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41520

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day	Year	3. Time of Death
CLARENCE	J.	PLUMMER JR.	JANUARY	22,	1997	

4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		QUEEN ANNES

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months	Days	If Under 24 Hrs.: Hours	Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
222-09-4084	1☒ M 2☐ F	76 Yrs.					3-5-1919	DELAWARE

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	QUEEN ANNES	SUDLERSVILLE	1☐ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
PO BOX 188	21668	USA

11. Maritel Stetus	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1☐ Never Married 2☐ Married 3☐ Widowed 4☒ Divorced	1☒ Yes 2☐ No If Yes, Giva Year or Dates: 2/42 THRU 8/44 Army	1☐ Yes 2☒ No Specify:	Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
~~10~~ 12		Retired- CHARTER BOAT CAPTAIN	BOATING

17. Father's Name (First, Middle, Last)	18. Mother's Nama (First, Middle, Meiden Surname)
CLARENCE J. PLUMMER SR.	FLORENCE E. KOHLENBERG

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)
COURT ORDER	

20e. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other place)	Data	20c. Location - City or Town, Stete
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶	

Physician /Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or haert failure. List only one cause on each line.

Approximete Intervat Between Onset and Death

Immadiata Causa (Final disease or condition resulting in daath)
a. UNKNOWN

Dua to (or as a consaquence of):

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Last
b.

Due to (or as e consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was casa referred to medical examinar?	28. Place of Death (Check only ona)
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☒ Other (Specify) COURT ORDER

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending investigation 6☒ Could not be datarmined		M	1☐ Yes 2☐ No	

28a. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifiar (Check only one)
1☐ **Certifying Physician:** To tha best of my knowladga, death occurred at the time, date and piece, and dua to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Dey, Year)
▶	OCME	FEBRUARY 10, 1998

30. Name and address of person who complatad causa of death (Item 23a) (Type, Print)
JOHN E. SMIALEK MD CHIEF MEDICAL EXAMINER 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
FEB 17 1998	▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41521

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DONTE ROBINSON
2. Date of Death Month / Day / Year: DEC 21 1997
3. Time of Death: 10:22 AM
4a. Facility Name *(If not institution, give street and number)*: NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: N/A
6. Sex: 1 [X] M 2 [ ] F
7. Age *(In yrs. last birthday)* Yrs.: If Under 1 Year Months / Days; If Under 24 Hrs. Hours: 7 / Min.:
8. Date of Birth *(Month, Day, Year)*: DEC 21 1997
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: FORT MEADE
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 7312-F AMES COURT #6
10f. Zip Code: 20755
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0; College (1-4or 5+): N/A
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: N/A
16b. Kind of Business/Industry: N/A

17. Father's Name *(First, Middle, Last)*: DONTE ANTIONE ROBINSON
18. Mother's Name *(First, Middle, Maiden Surname)*: LESLIE DENISE BLAND

19a. Informant's Name/Relationship *(Type, Print)*: LESLIE ROBINSON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7312-F AMES COURT #6 FT MEADE MD 20755

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: NNMC
Date: 11FEB98
20c. Location - City or Town, State: BETHESDA, MD

21. Signature of Funeral Service Licensee: ▶HM2 [signature] (HM2 SUMPTER)
22. Name and Address of Facility: 8901 Wisconsin Ave, Bethesda, Md 20889

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. EXTREME PREMATURITY

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No
26. Place of Death *(Check only one)*: Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other *(Specify)*

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D-44634
29d. Date signed *(Month, Day, Year)*: 2/10/98

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): J.R.GREENWALD, CDR, MC, USNR
NATIONAL NAVAL MEDICAL CENTER
BETHESDA MD 20889-5600

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 17 1998
32. Registrar's Signature: [signature]

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

KB

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41522

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: DESTINY ROBINSON
2. Date of Death Month / Day / Year: DEC 21 1997
3. Time of Death: 10:00 AM
4a. Facility Name *(If not institution, give street and number)*: NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Death: BETHESDA
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: N/A
6. Sex: 1☐ M 2☒ F
7. Age *(In yrs. last birthday)*: Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours: 7 / Min.
8. Date of Birth *(Month, Day, Year)*: DEC 21 1997
9. Birthplace *(State or Foreign Country)*: MARYLAND

Usual Residence of Decedent

10a. State: MARYLAND
10b. County: ANNE ARUNDEL
10c. City, Town or Location: FORT MEADE
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 7312-F AMES COURT #6
10f. Zip Code: 20755
10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*
14. Race - American Indian, Black, White, etc. *Specify:* BLACK
15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 0 / College (1-4or 5+):
16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: N/A
16b. Kind of Business/Industry: N/A
17. Father's Name *(First, Middle, Last)*: DONTE ANTIONE ROBINSON
18. Mother's Name *(First, Middle, Maiden Surname)*: LESLIE DENISE BLAND
19a. Informant's Name/Relationship *(Type, Print)*: LESLIE ROBINSON
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 7312-F AMES COURT #6, FT MEADE MD 20755
20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: NNMC
Date: 11FEB98
20c. Location - City or Town, State: BETHESDA, MD
21. Signature of Funeral Service Licensee: ▶ HM2 Sumpter (HM2 SUMPTER)
22. Name and Address of Facility: 8901 Wisconsin Ave, Bethesda Md 20889

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. EXTREME PREMATURITY
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

28. Place of Death *(Check only one)*: Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*
28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]
29c. License number: D-44634
29d. Date signed *(Month, Day, Year)*: 2/10/98

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): J.R.GREENWALD, CDR, MC, USNR
NATIONAL NAVAL MEDICAL CENTER
BETHESDA MD 20889-5600

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 17 1998
32. Registrar's Signature: [signature] Judy Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Items: 10d,12 per F.H. G-757 3/3/98 KEB

Certificate of Death

Reg. No. 97 41523

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: James Ottis Melton

2. Date of Death (Month, Dey, Yeer): Dec. 17, 1997

3. Time of Death: 4:55 PM

4e. Facility Name *(If not institution, give street and number)*: VA Maryland Health Care System

4b. City, Town, or Location of Death: BALTIMORE

4c. County of Death: N/A

Funeral Director

5. Social Security Number: 241 10 9874

6. Sex: 1☒M 2☐F

7. Age *(In yrs. last birthday)*: 80 Yrs.

If Under 1 Yeer: Months / Deys

If Under 24 Hrs.: Hours / Min.

8. Dete of Birth *(Month, Dey, Yeer)*: Jan. 20, 1917

9. Birthplece *(Stete or Foreign Country)*: North Carolina

Usuel Residence of Decedent

10e. State: Maryland

10b. County: Howard

10c. City, Town or Location: Columbia

10d. Inside City Limits: 1☒Yes 2☐No

10e. Street end Number: 6038 Waterloo Road

10f. Zip Code: 21045

10g. Citizen of Whet Country?: U.S.

11. Maritel Stetus: 1☐Never Married 2☒Married 3☐Widowed 4☐Divorced

12. Wes Decedent Ever in U.S. Armed Forces? 1☒Yes 2☐No. If Yes, Give Yeer or Detes: 1945 W.W. II

13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.): 1☐Yes 2☒No *Specify:*

14. Race - American Indien, Bleck, White, etc. *Specify:* White

15. Decedent's Education *(Specify only highest grede completed)*: Elementery/Secondery (0-12): 8th; College (1-4or 5+):

16e. Decedent's Usuel Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Carpenter

16b. Kind of Business/Industry: General Construction

17. Father's Name *(First, Middle, Lest)*: Douglas Lorenzo Boone

18. Mother's Name *(First, Middle, Meiden Surneme)*: Levy Melton

19e. Interment's Neme/Reletionship *(Type, Print)*: Betty E. Diehl / Daughter

19b. Meiling Address *(Street end Number or Rural Route Number, City or Town, Stete, Zip Code)*: 6038 Waterloo Road Columbia, Maryland 21045

20e. Method of Disposition: 1☒Burial 2☐Cremetion 3☐Removal from State 4☐Donation 5☐Other *(Specify)*

20b. Place of Disposition *(Neme of cemetery, cremetory or other pleca)*: Crest Lawn Mem. Gardens

Dete: 12/22/97

20c. Location - City or Town, Stete: Marriottsville, Md.

21. Signature of Funerel Service Licensee: Richard C Davis

22. Neme end Address of Feciility: Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225

Physician /Medical Examiner

23a. Pert I. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or heert feilure. List only one cause on eech line.

		Approximete Interval Between Onset and Deeth
Immediete Ceuse (Finel diseese or condition resulting in deeth)	a. Bradycardia	1 hr
	Due to (or es e consequence of):	
	b. Hypoxia	15 mins
Sequentielly list conditions, if eny, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in deeth) Lest	Due to (or es e consequence of):	
	c.	
	Due to (or es e consequenca of):	
	d.	

Pert II. **Other significent conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☒Unknown

24e. Wes an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings eveileble prior to completion of cause of deeth? 1☐Yes 2☐No

25. Wes case referred to medical exeminer? 1☐Yes 2☒No

26. Plece of Deeth *(Check only one)*: Hospital: 1☒Inpatient 2☐ER/Outpetient 3☐DOA; Other: 4☐Nursing Home 5☐Residence 8☐Other *(Specify)*

27. Menner of Deeth: 1☒Neturel 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigetion 6☐Could not be determined

28e. Dete of Injury *(Month, Dey Yeer)*

28b. Time of Injury M

28c. Injury et Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, fectory, office building, etc. *(Specify)*

28f. Location *(Street end Number or Rural Route Number, City or Town, Stete)*

29e. Certifier *(Check only one)*: 1☒**Certifying Physician:** To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) and menner es steted. 2☐**Medical Examiner:** On the basis of exemineticn end/or investigetion, in my opinion, death occurred et the time, dete end pleca, end due to the ceuse(s) end manner steted.

29b. Signeture and title of certifier: Hamang M. Patel

29c. License number: P09753

29d. Date signed *(Month, Dey, Yeer)*: 2/4/98

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print): Hamang M. Patel, M.D. 10 N. Greene Street, Baltimore, MD 21201

State Registrar

31. Dete filed *(Month, Dey, Yeer)*: FEB 24 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be completed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41524

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Adelene Brown

2. Date of Death (Month, Day, Year): DECEMBER 27, 1997

3. Time of Death: 0217

4a. Facility Name (If not institution, give street and number): PENINSULA REGIONAL MEDICAL CENTER

4b. City, Town, or Location of Death: SALISBURY

4c. County of Death: WICOMICO

Funeral Director

5. Social Security Number: 207-16-2615

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 87 Yrs.

If Under 1 Yaar: Months / Days

If Undar 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 23, 1910

9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD

10b. County: Somerset

10c. City, Town or Location: Princess Anne

10d. Inside City Limits: 1☒ Yes 2☐ No

10e. Street and Number: 11464 Bradford Avenue

10f. Zip Code: 21853

10g. Citizen of What Country: USA

11. Marital Status: 1☐ Naver Marriad 2☐ Married 3☒ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yaar or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yas or No- If Yes, specify Cuban, Maxican, Puarto Rican, atc.) 1☐ Yes 2☒ No Specify:

14. Raca - Amarican Indian, Black, Whita, atc. Specify: Black

15. Decedent's Education (Specify only highest grada completed): Elementary/Secondary (0-12): 7th; College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Domestic

16b. Kind of Businass/Industry: Domestic

17. Father's Neme (First, Middle, Last): Edward S. Handy

18. Mother's Name (First, Middle, Maiden Surneme): Janie Deshields

19a. Informant's Name/Relationship (Type, Print): Robert Handy

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code): 11464 Bradford Ave. Princess Anne MD 21853

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removat from State 4☐ Donetion 5☐ Other (Specify)

20b. Place of Disposition (Neme of cemetery, cremetory or other place): John Wesley Cemetery

Date: 1/3/98

20c. Locatlon - City or Town, State: Princess Anne, MD

21. Signature of Funeral Service Licansea: John A. Prince

22. Nama and Address of Facility: Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

ADELENE BROWN 207-16-2615

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death): a. Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last

b. Myocardial Infarction

Due to (or as a consequenca of):

c. End Stage Renal Disease

Dua to (or as a consequenca of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Wes an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings availabla prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Rasidence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicida 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be datarminad

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) and manner as stated. 2☐ **Madtcat Examiner:** On the basis of exemination end/or investigetion, in my opinion, deeth occurred et the time, dete end piece, end dua to tha ceuse(s) and manner stated.

29b. Signature and title of cartifier

29c. License number: D40715

29d. Date signed (Month, Dey, Year): 12/29/97

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print): Steven Hearne, MD 400 Eastern Shore Dr., Salisbury, Md.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State Registrar

31. Dete filed (Month, Day, Year): JAN 05 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rav 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 41525
Reg. No.

Physician /Medical Examiner

1. Decedent's Neme (First, Middle, Last): Norman Theodore Trump, SR.
2. Dete of Death Month: December Day: 26 Year: 1997
3. Time of Death: 4:05 A.M.
4e. Facility Name (If not institution, give street end number): FREDERICK MEMORIAL HOSPITAL
4b. City, Town, or Locetion of Deeth: FREDERICK
4c. County of Death: FREDERICK

Funeral Director

5. Social Security Number: 219-20-2066
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. lest birthday): 87 Yrs. | If Under 1 Year: Months / Deys | If Under 24 Hrs.: Hours / Min.
8. Dete of Birth (Month, Dey, Year): Mar-17-1910
9. Birthpiece (Stete or Foreign Country): PENNSYLVANIA

Usuel Rasidance of Decadent

10e. Stete: MD.
10b. County: FREDERICK
10c. City, Town or Location: FREDERICK
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street end Number: 355 MONTEVUE LANE
10f. Zip Code: 21702
10g. Citizen of Whet Country?: u.s.a.
11. Maritel Stetus: 1☐ Never Merried 2☐ Merried 3☐ Widowed 4☒ Divorced
12. Wes Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Rece - American Indien, Bleck, White, etc. Specify: WHITE
15. Decedent's Education (Specify only highest grade completed): Elementery/Sacondary (0-12): 11th | College (1-4or 5+):
16a. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired): POLICE OFFICER
16b. Kind of Business/Industry: SECURITY
17. Father's Neme (First, Middle, Last): JAMES TRUMP
18. Mother's Name (First, Middle, Maiden Sumame): BARBARA A. SMITH
19a. Informent's Neme/Reletionship (Type, Print): BONNIE K. HARRIS (DAUGHTER)
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): 6906 FOX CHASE COURT NEW MARKET, MD. 21774
20e. Mathod of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removel from State 4☐ Donetion 5☐ Other (Specify)
20b. Plece of Disposition (Nema of cemetery, cremetory or other piece): SMITHSBURG CREMATORY
Dete: 12-27-97
20c. Location - City or Town, Stete: SMITHSBURG, MARYLAND
21. Signature of Funerel Service Licensee: Robert E Dailey Jr
22. Name end Address of Facility: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 N. MARKET ST. FREDERICK, MD. 21701

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert fellure. List only one ceuse on eech lina.

Approximete Interval Between Onset end Deeth

Immediate Cause (Finel disease or condition resulting in deeth)
e. Dehydration
Dua to (or es e consequance of):
b. Hypercalcemia
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury thet initieted events resulting in deeth) Lest
Due to (or es e consequence of):
c. Renal Cell Cancer Metestatic
Due to (or es a consequence of):
d.

Days / Week / Year

Pert II. Other elgnificant conditiona contributing to deeth but not resulting in the underlying cause given in Part I.: Diabetes

23b. Did tobacco use contribute to the cause of death? 1☐ Yee 2☐ No 3☐ Probably 4☒ Unknown

24e. Wes en eutopsy performed? 1☐ Yas 2☐ No

24b. Wara autopsy findings aveilable prior to compiation of cause of deeth? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yas 2☒ No

26. Piece of Deeth (Check only ona): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 8☐ Could not be detarmined

28a. Date of Injury (Month, Dey Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Placa of Injury - At home, ferm, street, fectory, office building, etc. (Specify)
28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

29e. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end piece, and due to the cause(s) end manner as stated. 2☐ Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, dete end placa, end due to the ceuse(s) end menner stated.

29b. Signeture and title of certifier: William H. Johnson
29c. License number: D47556
29d. Dete signed (Month, Dey, Year): 12/26/97

30. Name and address of person who completed causa of deeth (Item 23a) (Type, Print): WILLIAM H. JOHNSON 187 THOMAS JOHNSON DRIVE, FREDERICK, MD 21702

State Registrar

31. Date filed (Month, Dey, Year): DEC 30 1997
32. Registrer's Signeture: Julia Davidson Rankin

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41526

Physician /Medical Examiner

1. Decedent's Neme *(First, Middle, Last)*: MICHAEL JESSE DEB
2. Dete of Deeth — Month: APR Day: 27 Year: 1997
3. Time of Death: 7:15 AM
4a. Facility Neme *(If not institution, give street and number)*: NATIONAL NAVAL MEDICAL CENTER
4b. City, Town, or Location of Deeth: BETHESDA
4c. County of Deeth: MONTGOMERY

Funeral Director

5. Social Security Number: N/A
6. Sex: 1☐ M 2☐ F — X
7. Age *(In yrs. last birthday)* Yrs.: If Under 1 Yeer — Months: Deys: If Under 24 Hrs. — Hours: 6 Min.:
8. Dete of Birth *(Month, Dey, Yeer)*: APR 27 1997
9. Birthplece *(State or Foreign Country)*: MARYLAND

Usuel Residence of Decedent

10a. Stete: VA
10b. County: FAIRFAX
10c. City, Town or Locetion: HERNDON
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 1133 CYPRESS TREE PLACE
10f. Zip Code: 22070
10g. Citizen of Whet Country?: UNITED STATES
11. Meritel Stetus: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Wes Decedent Ever in U.S. Armed Forces?: 1☐ Yes 2☒ No If Yes, Give Yeer or Detes:
13. Wes Decedent of Hispenic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexicen, Puerto Rican, etc.): 1☐ Yes 2☒ No *Specify:*
14. Rece - Americen Indien, Bleck, White, etc. *Specify:* WHITE
15. Decedent's Education *(Specify only highest grade completed)*: Elemantery/Secondery (0-12): 0 College (1-4or 5+):
16a. Decedent's Usuel Occupetion *(Give kind of work done during most of working life. DO NOT use retired)*: N/A
16b. Kind of Businass/Industry: None
17. Fether's Neme *(First, Middle, Last)*: SUBRATO JESSE DEB
18. Mother's Name *(First, Middle, Maiden Sumame)*: LISA LOUISE BRENNAN
19a. Informent's Neme/Reletionship *(Type, Print)*: SUBRATO DEB/FATHER
19b. Meiling Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 1133 CYPRESS TREE PLACE, HERNDON VA 22070
20a. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☐ Removal from Stete 4☐ Donetion 5☒ Other *(Specify)*
20b. Piece of Disposition *(Name of cemetery, crematory or other place)*: NNMC
Dete: 5/8/97
20c. Locetion - City or Town, Stete: BETHESDA MD
21. Signeture of Funerel Servica Licensee: M. Bowden
22. Neme end Address of Feciility: NATIONAL NAVAL MEDICAL CENTER 8901 WISCONSIN AVE., BETHESDA MD 20889-5600

Physician /Medical Examiner

23a. Pert1. Enter the diseese, or complicetions thet caused the deeth. Do not anter the mode of dying, such es cardiec or raspiratory arrest, shock, or heert feilure. List only one cause on each line. — Approximeta Interval Between Onset end Death

Immedeite Cause (Finel disease or condition resulting in deeth)
a. SEPSIS
Due to (or as e consequence of):
Sequentially list conditions, if any, leading to immadiate causa. Entar Underlying Cause (Diseese or Injury thet initieted events resulting in deeth) Last
b. EXTREME PREMATURITY
Due to (or es e consequence of):
c.
Due to (or es e consequenca of):
d.

Pert II. **Other significant conditions** contributing to death but not resulting in the undarlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Wes case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Deeth *(Check only one)*: Hospitel: 1☒ Inpetient 2☐ ER/Outpetient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 8☐ Other *(Specify)*
27. Manner of Deeth: 1☒ Neturel 2☐ Accidant 3☐ Suicide 4☐ Homicida 5☐ Pending Investigation 8☐ Could not be determined
28a. Dete of Injury *(Month, Dey Yeer)*
28b. Time of Injury M
28c. Injury et Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Plece of Injury - At home, ferm, street, factory, office building, etc. *(Specify)*
28f. Locetion *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1☒ **Certifying Physician:** To tha best of my knowladga, daath occurred at tha tima, data and plece, end due to the cause(s) and mannar as stated. 2☐ **Medical Examiner:** On the basis of axamination end/or investigetion, in my opinion, deeth occurred at the time, date and piece, end due to the causa(s) and menner steted.

29b. Signeture end title of certifier: R. Moores MD
29c. License number: D-41551
29d. Dete signed *(Month, Day, Year)*: 04/29/97
30. Nema end address of person who completed causa of death (Item 23a) (Type, Print): R. MOORES, LTCL, MC, USA — NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

State Registrar

31. Date filed *(Month, Day, Year)*: MAR 10 1998
32. Registrer's Signetura: Lisha Davidson-Rondella

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97 41527

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BABY BOY GRAVES

2. DATE OF DEATH Month: 9 Day: 17 Year: 97

3. TIME OF DEATH: 9:10A M

4. SOCIAL SECURITY NUMBER: None

5. SEX: 1 ☒ M 2 ☐ F

6. AGE (In yrs. last birthday) YRS.: IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min. 33

7. DATE OF BIRTH (Month, Day, Year): 9/17/97

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Prince Georges Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly

9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: md

10b. COUNTY: Prince Georges

10c. CITY, TOWN OR LOCATION: Hyattsville

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 5700 42nd Avenue,

10f. ZIP CODE: 20781

10g. CITIZEN OF WHAT COUNTRY?: US

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 0
College (1-4 or 5+): 0

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Infant

16b. KIND OF BUSINESS/INDUSTRY: Infant

17. FATHER'S NAME (First, Middle, Last): Reginald Kevin Hush

18. MOTHER'S NAME (First, Middle, Maiden Surname): Robin Francine Graves

19a. INFORMANT'S NAME (Type/Print): Robin Graves

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5700 42nd Avenue #304 Hyattsville md 20781

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cremetory or other place): MEDEX DATE: 1-3-98

20c. LOCATION — City or Town, State: FALL RIVER MC

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]

22. NAME AND ADDRESS OF FACILITY: PGHC 3001 Hospital Dr Cheverly MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Extreme Prematurity (23-24 weeks gestation)

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Respiratory distress syndrome

DUE TO (OR AS A CONSEQUENCE OF):

c. Pneumothorax, Right.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☒ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD.

29c. LICENSE NUMBER: D27628

29d. DATE SIGNED (Month, Day, Year): 9/17/97

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Isabelita G. Frattarola, M.D. Prince Georges Hospital Center Cheverly, Md

31. DATE FILED (Month, Day, Year): MAR 10 1998

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

KB.

DHMH-18 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 001528

Reg. No.

Items:23a part I,27 per MEO G-757 3/10/98 dh

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): David Charles Small

2. Date of Death (Month, Day, Year): November 26, 1997

3. Time of Death: 1856

4a. Facility Name (If not institution, give street and number): Washington County Hospital

4b. City, Town, or Location of Death: Hagerstown

4c. County of Death: Washington

Funeral Director

5. Social Security Number: 218-02-6307

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 37 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): May 14, 1960

9. Birthplace (State or Foreign Country): Georgia

Usual Residence of Decedent

10a. State: Maryland

10b. County: Washington

10c. City, Town or Location: Hagerstown

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 18522 Indian Cottage Road

10f. Zip Code: 21740

10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): salesman

16b. Kind of Business/Industry: R. J. Reynolds

17. Father's Name (First, Middle, Last): Roy Melvin Small

18. Mother's Name (First, Middle, Maiden Surname): Janet Lorraine Ankerbrand

19a. Informant's Name/Relationship (Type, Print): Janet L. Small Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 555 Jefferson St., Apt. 4, Hagerstown, Maryland 21740

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Smithsburg Crematory

Date: 11/28/97

20c. Location - City or Town, State: Smithsburg, Maryland

21. Signature of Funeral Service Licensee: Gerald N. Minnich

22. Name and Address of Facility: Gerald N. Minnich Funeral Home, 305 N. Potomac Street, Hagerstown, Maryland 21740

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. FATTY LIVER

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and Title of Certifier: [signature]

29c. License number: OCME

29d. Date signed (Month, Day, Year): November 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): DAVID R. FOWLER, MD Asst. Medical Examiner 111 Penn St. Balto MD 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): MAR 10 1998

32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

Item: 24a Per MD Film G-757 3-4-98RC

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible

State of Maryland / Department of Health and Mental Hygiene

97 41529

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): ESTHER C. GANNON
2. Date of Death (Month, Day, Year): Dec. 4 1997
3. Time of Death: 13:29 PM
4a. Facility Name (If not institution, give street and number): Liberty Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: unknown
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 81 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Dey, Yeer): Sept. 3, 1916
9. Birthplace (Stete or Foreign Country): Unknown

Usual Residence of Decedent

10a. Stete: Unknown
10b. County: Unknown
10c. City, Town or Location: Unknown
10d. Inside City Limits: unknown 1☐ Yes 2☐ No
10e. Street and Number: Unknown
10f. Zip Code: Unknown
10g. Citizen of What Country? Unknown

To Be Completed by Funeral Director

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? unknown 1☐ Yes 2☐ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) unknown 1☐ Yes 2☐ No Specify:
14. Race - American Indien, Bleck, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: Unknown
17. Father's Name (First, Middle, Last): Unknown
18. Mother's Name (First, Middle, Meiden Sumame): Unknown
19a. Informant's Name/Reletionship (Type, Print): Unknown
19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code): Unknown
20a. Method of Disposition: 1☐ Burial 2☐ Cremetion 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) In State
20b. Place of Disposition (Neme of cemetery, cremetory or other piece)
Dete
20c. Location - City or Town, State
21. Signature of Funeral Service Licensee: Ronald S. Wade, Director — Ronald S. Wade 12/10/97
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Ceuse (Final disease or condition resulting in death)
e. RESPIRATORY FAILURE

Due to (or as a consequence of):
b. PNEUMONIA

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Due to (or es e consequence of):
c.

Due to (or es e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC BRAIN SYNDROME

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☑ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No XX

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☑ Yes 2☐ No

26. Place of Death (Check only one)
Hospital: 1☐ Inpatient 2☑ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29a. Certifier (Check only one): 1☑ **Certifying Phyaician:** To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated. 2☐ **Medical Examinar:** On the besis of exemination and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the cause(s) and manner stated.

29b. Signature and title of certifier: Gregorio Amafori
29c. License number: D04826
29d. Date signed (Month, Dey, Year): DEC 4, 1997

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print): LIBERTY MEDICAL CENTER

State Registrar

31. Date filed (Month, Dey, Yeer): MAR 04 1998
32. Registrer's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Items: 27, 28a-f per MEO G-757 3/18/98 (reb)

Reg. No. 97 41530

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Anthony H. Hastings
2. Date of Death (Month, Day, Year): November 25 1997
3. Time of Death: 15:05 PM
4a. Facility Name (If not institution, give street and number): Union Memorial Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore City

Funeral Director

5. Social Security Number: 21228-1784
6. Sex: 1 ☒ M 2 ☐ F
7. Age (In yrs. last birthday): 65 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 8, 1932
9. Birthplace (State or Foreign Country): unknown

Usual Residence of Decedent

10a. State: Maryland
10b. County: Baltimore City
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☒ Yes 2 ☐ No
10e. Street and Number: 3436 Chestnut Avenue
10f. Zip Code: 21218
10g. Citizen of What Country?: U.S.A.

11. Marital Status: unknown — 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): unknown — College (1-4or 5+): unknown
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): unknown
16b. Kind of Business/Industry: unknown

17. Father's Name (First, Middle, Last): unknown
18. Mother's Name (First, Middle, Maiden Surname): unknown

19a. Informant's Name/Relationship (Type, Print): Patricia Hastings/sister
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): unknown

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in state
20b. Place of Disposition (Name of cemetery, crematory or other place)
Date
20c. Location - City or Town, State

21. Signature of Funeral Service Licensee: Ronald S. Wade, Director
22. Name and Address of Facility: State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
e. Pulmonary Embolism — 2 hours
Due to (or as a consequence of):
b. Atrial Fibrillation — 3 days
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

CERTIFICATION APPROVED BY MEDICAL EXAMINER

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
Laceration of right kidney due to fall

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 1 ☐ Yes 2 ☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one): Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year): Sept. 19, 1997
28b. Time of Injury: Unknown M
28c. Injury at Work? 1 ☐ Yes 2 ☒ No
28d. Describe how injury occurred: Subject fell of ladder
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 3436 Chestnut Ave. Baltimore, Md.

29a. Certifier (Check only one): 1 ☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: MD
29c. License number: AT 2438946
29d. Date signed (Month, Day, Year): November 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): MINCY YI 201 East University parkway, Baltimore, MD 21218

State Registrar

31. Date filed (Month, Day, Year): MAR 1 8 1998
32. Registrar's Signature: Julia Davidson-Randall

Medical Certification: To Be Completed by Physician/Medical Examiner

To be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Anthony Hastings

DHMH 16 Rev 6/95

97-7541-510
CMK
UNK.#97-280
MICHAEL BOYD

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41531

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
MICHAEL BOYD	DECEMBER 29, 1997	2049PM

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
UNION MEMORIAL HOSPITAL E.R.	BALTIMORE CITY	Baltimore City

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
unknown	1☒ M 2☐ F	42 Yrs.			March 23, 1955	unknown

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore City	Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
1812 St. Paul Street	21202	U.S.A.

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
unknown 1☐ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	unknown 1☐ Yes 2☐ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
unknown	unknown	unknown	unknown

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
unknown	unknown

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
unknown	unknown

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) in state			

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
Joseph B. Van Sant Joseph B. Van Sant	State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Head Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.
Due to (or as a consequence of):
c.
Due to (or as e consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

Chronic Alcoholism

23b. Did tobacco use contribute to the cause of death?
1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☒ Yes 2☐ No	1☒ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☒ Yes 2☐ No	Hospital: 1☐ Inpatient 2☒ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined	12/29/97	2000 M	1☐ Yes 2☒ No	Slipped fell down steps

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify): Residence

28f. Location (Street and Number or Rural Route Number, City or Town, State): 1812 St. Paul St. 21202

29a. Certifier (Check only one)
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☒ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
[signature] MD	O.C.M.E.	DECEMBER 30, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
[illegible] Wecker, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date Filed (Month, Day, Year)	32. Registrar's Signature
MAR 18 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41532

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): WILLIAM EDWARD HART

2. Date of Death (Month, Day, Year): Sept. 11, 1997

3. Time of Death: 6:22p.m.

4a. Facility Name (If not institution, give street and number): PHYSICIANS MEMORIAL HOSPITAL

4b. City, Town, or Location of Death: LAPLATA

4c. County of Death: CHARLES

Funeral Director

5. Social Security Number: 579-46-5532

6. Sex: 1☒M 2☐F

7. Age (In yrs. last birthday): 61 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): SEPT. 14, 1935

9. Birthplace (State or Foreign Country): WASHINGTON, D.C.

Usual Residence of Decedent

10a. State: MARYLAND

10b. County: CHARLES

10c. City, Town or Location: NANJEMOY

10d. Inside City Limits: 1☐Yes 2☒No

10e. Street and Number: BOX 114 D HOLLY SPRINGS RD. 3940 CHANCELOR RUN PLACE

10f. Zip Code: 20662-0114

10g. Citizen of What Country?: UNITED STATES

11. Marital Status: 1☒Never Married 2☐Married 3☐Widowed 4☐Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐Yes 2☒No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐Yes 2☒No Specify:

14. Race - American Indian, Black, White, etc. Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 8TH GRADE

College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): CEMENT FINISHER/DRYWALLER

16b. Kind of Business/Industry: CONSTRUCTION

17. Father's Name (First, Middle, Last): WILLIAM BROWN

18. Mother's Name (First, Middle, Maiden Surname): MARIE HART GRAY

19a. Informant's Name/Relationship (Type, Print): MICHAEL D. HART / COUSIN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9612 CALTOR LANE, FORT WASHINGTON, MARYLAND 20744

20a. Method of Disposition: 1☒Burial 2☐Cremation 3☐Removal from State 4☐Donation 5☐Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): OAK GROVE CHURCH CEMETERY

Date: 9/15/97

20c. Location - City or Town, State: GRAYTON, MARYLAND

21. Signature of Funeral Service Licensee: Lydia C. Thornton Johnson

LYDIA C. THORNTON JOHNSON MO0583

22. Name and Address of Facility: THORNTON FUNERAL HOME, P.A. 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardio Pulmonary Arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. End stage Lung Cancer with Metastasis

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐Yes 2☐No 3☐Probably 4☐Unknown

24a. Was an autopsy performed? 1☐Yes 2☒No

24b. Were autopsy findings available prior to completion of cause of death? 1☐Yes 2☐No

25. Was case referred to medical examiner? 1☐Yes 2☒No

26. Place of Death (Check only one): Hospital: 1☒Inpatient 2☐ER/Outpatient 3☐DOA Other: 4☐Nursing Home 5☐Residence 6☐Other (Specify)

27. Manner of Death: 1☒Natural 2☐Accident 3☐Suicide 4☐Homicide 5☐Pending investigation 6☐Could not be determined

28a. Date of Injury (Month, Day, Year): 9/11/97

28b. Time of Injury: M

28c. Injury at Work? 1☐Yes 2☐No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒**Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐**Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D-46979

29d. Date signed (Month, Day, Year): 9/12/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Sein, Collins, MD 11345 Pembrooke Square Suite 104 WALDORF, MD 20603

State Registrar

31. Date filed (Month, Day, Year): SEP 15 1997

32. Registrar's Signature: Julia Davidson-Randall

To Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

William Edward Hart

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41533

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Baby Boy Linton
2. Date of Death — Month: June Day: 2 Year: 1997
3. Time of Death: 3:45a.m.
4a. Facility Name (If not institution, give street and number): The Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: None
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 0 Yrs. — If Under 1 Year: Months / Days; If Under 24 Hrs.: Hours / Min.: 5
8. Date of Birth (Month, Day, Year): June 2, 1997
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 2322 East Chase Street
10f. Zip Code: 21205
10g. Citizen of What Country?: USA

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No — If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black
15. Decedent's Education (Specify only highest grade completed) — Elementary/Secondary (0-12): 0 — College (1-4or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Infant
16b. Kind of Business/Industry: Infant
17. Father's Name (First, Middle, Last): Tony Gregory
18. Mother's Name (First, Middle, Maiden Surname): Rhonda Renee Linton
19a. Informant's Name/Relationship (Type, Print): Rhonda Linton / Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2322 East Chase Street Baltimore, MD 21205
20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify): Disposal
20b. Place of Disposition (Name of cemetery, crematory or other place): Johns Hopkins Hospital — Date: 6/2/97
20c. Location - City or Town, State: Baltimore, MD
21. Signature of Funeral Service Licensee: Raymond Johnson
22. Name and Address of Facility: Johns Hopkins Hospital 600 N. Wolfe Street, Baltimore, MD 21287

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Prematurity	22 6/7 wks
Due to (or as a consequence of): b.	Premature rupture of membrane	2 hours
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.	Preterm labor and delivery	2 hours
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

28. Place of Death (Check only one) — Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Deborah Martin
29c. License number: RES-000
29d. Date signed (Month, Day, Year): June 2nd 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Deborah J. Martin 600 N. Wolfe St. Baltimore, MD 21287

State Registrar

31. Date filed (Month, Day, Year): MAR 27 1998
32. Registrar's Signature: Julia Davidson-Randall

K.B

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41534

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Baby Girl Tabb
2. Date of Death: Month August Day 19 Year 1997
3. Time of Death: 3:21 a.m.
4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: NONE
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): Yrs.; If Under 1 Year: Months, Days; If Under 24 Hrs.: Hours, Min. 5
8. Date of Birth (Month, Day, Year): August 19, 1997
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2431 E. Jefferson Street
10f. Zip Code: 21205
10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4 or 5+): 0
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Infant
16b. Kind of Business/Industry: Infant

17. Father's Name (First, Middle, Last): Robert Johnson
18. Mother's Name (First, Middle, Maiden Surname): Michele Tabb

19a. Informant's Name/Relationship (Type, Print): Michele Tabb / Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2431 E. Jefferson St., Baltimore, MD 21205

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☒ Other (Specify) Disposal
20b. Place of Disposition (Name of cemetery, crematory or other place): Johns Hopkins Hospital
Date: 8/19/97
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Raymond Johnson
22. Name and Address of Facility: Johns Hopkins Hospital, 600 N. Wolfe St., Baltimore, MD 21287

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	e. Cardiac Arrest	1-4 minutes
Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Premature lungs	minutes
Due to (or as a consequence of):		
	c. Severe Prematurity	
Due to (or as a consequence of):		
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA; Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: [signature]
29c. License number: D37128
29d. Date signed (Month, Day, Year): 1/30/98
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nikita Levy 600 N. Wolfe Street Baltimore, Maryland 21287

State Registrar

31. Date filed (Month, Day, Year): MAR 27 1998
32. Registrar's Signature: Lydia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

KB

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #19a, 4/7/97, JW, Montg. Cty. — *Certificate of Death* — Reg. No. 97 41535

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frederick A. Blumer
2. Date of Death (Month, Day, Year): March 28, 1997
3. Time of Death: 7:33 AM
4a. Facility Name (If not institution, give street and number): Montgomery General Hospital
4b. City, Town, or Location of Death: Olney
4c. County of Death: Montgomery

Funeral Director

5. Social Security Number: 578-07-9547
6. Sex: 1☒ M 2☐ F
7. Age (In yrs. last birthday): 93 Yrs. — If Under 1 Year: Months / Days — If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 25, 1903
9. Birthplace (State or Foreign Country): Washington, D.C.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Silver Spring
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 3701 International Drive, #603
10f. Zip Code: 20906
10g. Citizen of Whet Country?: USA

11. Maritel Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Yeer or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - Americen Indian, Bleck, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4or 5+): 4
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Broker
16b. Kind of Business/Industry: Real Estate

17. Father's Name (First, Middle, Last): Frederick A. Blumer
18. Mother's Neme (First, Middle, Maiden Sumame): Jerry Williams

19e. Informant's Name/Relationship (Type, Print): Frederick ~~Galeck~~ Galeck / ~~Son-in-law~~ Grandson
19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 216 Connolly Street, Marysville, Ohio 43040

20a. Method of Disposition: 1☐ Buriel 2☒ Cremetion 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Fort Lincoln Crematory
Date: 4/1/97
20c. Location - City or Town, State: Brentwood, Maryland

21. Signature of Funeral Service Licensee: John T. Hines
22. Name and Address of Feciility: Hines-Rinaldi Funeral Home, 11800 New Hampshire Avenue, Silver Spring, Maryland 20904

JW

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death) a.	Subdural Hematoma	12 hrs.
Due to (or as a consequence of): b.		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last — Due to (or as a consequence of): c.		
Due to (or as a consequence of): d.		

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☒ Yes 2☐ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Menner of Death: 1☐ Natural 2☒ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year): March 27 97
28b. Time of Injury: unk M
28c. Injury at Work? 1☐ Yes 2☒ No
28d. Describe how Injury occurred: fell
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Home
28f. Location (Street and Number or Rural Route Number, City or Town, State): 3701 International Dr

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☐ **Certifying Physician:** To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) end manner as stated. 2☒ **Medical Examiner:** On the basis of examination end/or investigation, in my opinion, death occurred et the time, date end piace, and due to the cause(s) end manner stated. 603 SS MD

29b. Signature end titie of certifier: John Lamber
29c. License number: D08546
29d. Date signed (Month, Day, Year): March 31 1997 MD

30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print): John Lamber 8218 Wisconsin Ave Bethesda MD

State Registrar

31. Date filed (Month, Day, Year): APR 01 1997
32. Registrar's Signature: Julia Davidson-Randall

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

10

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend: items #24ab,25 Per MD Film G-758 4-13-98 RC

Certificate of Death

Reg. No. 97 41536

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month / Day / Year	3. Time of Death
Baby	George	September 7 1997	1100

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St Agnes Health Care	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (in yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
NONE	1☑ M 2☐ F	Yrs.		1 / 50	09/07/97	MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD		Baltimore	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
3507 W. Franklin Street	21229	USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☐ Yes 2☒ No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed) N/A		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
0	0	N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Unknown	Delterese Denise George

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ST. AGNES HOSP	900 S. CATON AVE 21229

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	St. Agnes Hosp.	9-7-97	Baltimore MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Cathy Berg /per R. Colyer	St. Agnes Hosp. 900 S. Caton Ave, Baltimore MD 21229

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. SEVERE PREMATURITY	
	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b.	
	Due to (or as a consequence of):	
	c.	
	Due to (or as a consequence of):	
	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. **Did tobacco use contribute to the cause of death?** 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☒ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 8☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)
1☒ **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶ A. Hatoum M.D.	D37452	9/7/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)
AYAD HATOUM, M.D. ST. AGNES HOSPITAL, BALTIMORE, MD. 21229

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
APR 13 1998	Julia Davidson-Randall

NAME: George, Baby Boy of DeHeres

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend: #14 Per KB Film G758 4-17-98RC

Certificate of Death

Reg. No. 97 41537

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Year	3. Time of Death
JONATHAN MEJIA	Sept. 15, 1997	2:48 p.m.

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
SHADY GROVE ADVENTIST HOSPITAL	ROCKVILLE	MONTGOMERY

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
N/A	1☒ M 2☐ F	Yrs.		10	Sept. 5, 1997	MARYLAND

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD	MONTGOMERY	TAKOMA PARK	1☒ Yes 2☐ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
510 DOMER AVENUE	20912	

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	1☐ Yes 2☒ No If Yes, Give Year or Dates:	1☒ Yes 2☐ No Specify:	Specify: ~~White~~ South American

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
N/A	N/A	N/A	N/A

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
Luvin Martinez	BERTA MEJIA

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Shady Grove Hospital	510 DOMER AVENUE, TAKOMA PARK, MD 20912

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	SHADY GROVE ADV. HOSPITAL	1997 Sept.	ROCKVILLE, MD

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
KILTIE LEACH- V-PRES.	SHADY GROVE ADVENTIST HOSPITAL 9901 Medical Center Dr., ROCKVILLE, MD 20850

Physician /Medical Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part1. Enter the disease, or complicetions thet caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or haart failure. List only ona causa on aach lina.

		Approximate Interval Between Onset and Death
Immediate Cause (Finai disease or condition resulting in death)	a. INTRAVENTRICULAR HEMORRHAGE	10 days
	Dua to (or as a consequence of):	
Sequentially iist conditions, if eny, leading to immediete cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	b. PREMATURITY -- GESTATIONAL AGE 27 WEEKS	
	Due to (or as a consequence of):	
	c.	
	Due to (or es e consequence of):	
	d.	

Part ii. **Other significant conditions** contributing to death but not resulting in tha underlying cause given in Part I.

23b. Did tobacco use contributa to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☒ No	1☐ Yes 2☐ No

25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1☐ Yes 2☒ No	Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA	Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined		M	1☐ Yes 2☐ No	

28e. Piece of Injury - At home, farm, straat, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1☒ **Certifying Physician:** To the best of my knowledge, death occurred et the time, date and piece, end due to the ceuse(s) and menner as stated. 2☐ **Medical Examinar:** On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
Robert J. Buczek M.D.	27899	9/20/97

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)
ROBERT BUCZEK, MD 9901 MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
APR 17 1998	Julie Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 16 Rev 6/95

97 41538

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): male Oliver
2. DATE OF DEATH (Month, Day, Year): 5 7 97
3. TIME OF DEATH: 237P M
4. SOCIAL SECURITY NUMBER: none
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. 5
7. DATE OF BIRTH (Month, Day, Year): 5 7 97
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Prince Georges Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly
9c. COUNTY OF DEATH: prince Georges

RESIDENCE OF DECEDENT

10a. STATE: md
10b. COUNTY: prince Georges
10c. CITY, TOWN OR LOCATION: Riverdale
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 6204 Greenbelt parkway
10f. ZIP CODE: 20737
10g. CITIZEN OF WHAT COUNTRY? U.S.
11. MARITAL STATUS: Infant — 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: Infant
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Infant — College (1-4 or 5+): Infant
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Infant
16b. KIND OF BUSINESS/INDUSTRY: Infant
17. FATHER'S NAME (First, Middle, Last): Unknown
18. MOTHER'S NAME (First, Middle, Maiden Surname): Kelly Oliver
19a. INFORMANT'S NAME (Type/Print): Kelly Oliver
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6204 Greenbelt parkway Greenbelt md 207 37
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ____
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MEDEP — DATE: 10/11/97
20c. LOCATION — City or Town, State: UNIVERSITY MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: PGHC CHEVERLY MD 20785

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Prematurity	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D42555
29d. DATE SIGNED (Month, Day, Year): ▶ 4/15/98
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lauren Rodgers, M.D.
31. DATE FILED (Month, Day, Year): APR 27 1998
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

97 01539

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

To Be Completed by Funeral Director

1. Decedent's Name (First, Middle, Last): EDWARD WAREHAM COCHRAN
2. Date of Death: Month 5 Day 28 Year 97
3. Time of Death: 2:50 PM
4a. Facility Name (If not institution, give street and number): 18912 Preston Road
4b. City, Town, or Location of Death: Hagerstown
4c. County of Death: Washington
5. Social Security Number: 219-14-9067
6. Sex: 1 M 2 F
7. Age (In yrs. last birthday): 76 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth: March 2, 1921
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County: Washington
10c. City, Town or Location: Hagerstown
10d. Inside City Limits: 1 Yes 2 No
10e. Street and Number: 18912 Preston Road
10f. Zip Code: 21742
10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No. If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No. Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): President
16b. Kind of Business/Industry: Insurance Agency

17. Father's Name (First, Middle, Last): James E. Cochran
18. Mother's Name (First, Middle, Maiden Surname): Mildred Wareham

19a. Informant's Name/Relationship (Type, Print): Jane Stickell Cochran, Wife
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18912 Preston Road, Hagerstown, Maryland 21742

20a. Method of Disposition: 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Rose Hill Cemetery
Date: June 2
20c. Location - City or Town, State: Hagerstown, Maryland

21. Signature of Funeral Service Licensee: Kelly A. Yourker
22. Name and Address of Facility: Douglas A. Fiery Funeral Home, 1331 Eastern Blvd. N., Hagerstown, Maryland 21742

Medical Certification: To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Chronic Myelomonocytic Leukemia 205.0 — 3 years
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last: b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 Yes 2 No
24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No
26. Place of Death (Check only one): Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA. Other: 4 Nursing Home 5 Residence 6 Other (Specify)

27. Manner of Death: 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined
28a. Date of Injury (Month, Day, Year)
28b. Time of Injury
28c. Injury at Work? 1 Yes 2 No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Michael J. McCormack M.D.
29c. License number: D41667
29d. Date signed (Month, Day, Year): 5/30/97
29e. Name and address of person who completed cause of death (Item 23a) (Type, Print): Michael McCormack MD 11110 Medical Campus Rd Hagerstown MD 21742
31. Date filed (Month, Day, Year): JUN 03 1997
32. Registrar's Signature: John Stephen Rockel

To the Funeral Director: After the certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use on the burial/removal permit.

Important: If Item 21 is marked other than "natural", or there is a blank where any injury or other traumatic event, the Medical Examiner must be notified of this fact.

within 24 hours after death.

18 Rev 8/96

6

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 41540

ITEMS: #8 PER F.H. G764 10-2-98 WR.
Items:5,6,7,10c,e,f per Informant 3/22/99 reb

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: Mary Ella Pitt

2. Date of Death — Month: January; Day: 14; Year: 1997

3. Time of Death: 0627

4a. Facility Name *(If not institution, give street and number)*: Fallston Gen. Hospital

4b. City, Town, or Location of Death: Fallston

4c. County of Death: Harford

Funeral Director

5. Social Security Number: ~~199-28-6804~~ 218-07-9699

6. Sex: ~~1☐ M~~ X 2☐ F

7. Age *(In yrs. last birthday)*: ~~60~~ 83 Yrs.

If Under 1 Year — Months / Days

If Under 24 Hrs. — Hours / Min.

8. Date of Birth *(Month, Day, Year)*: ~~May 17, 1936~~ 12-18-1913

9. Birthplace *(State or Foreign Country)*: PA

Usual Residence of Decedent

10a. State: MD

10b. County: Harford

10c. City, Town or Location: ~~Edgewood~~ Havre de Grace

10d. Inside City Limits: X 1☐ Yes 2☐ No

10e. Street and Number: ~~812 Mt. Vernon Ct.~~ 2215 Williams Drive

10f. Zip Code: 21078

10g. Citizen of What Country?: USA

11. Marital Status: 1☒ ~~Never~~ Married 2☐ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No — If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 1☐ Yes 2☒ No *Specify:*

14. Race - American Indian, Black, White, etc. *Specify:* Black

15. Decedent's Education *(Specify only highest grade completed)*
Elementary/Secondary (0-12): 11
College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: machine operator

16b. Kind of Business/Industry:

17. Father's Name *(First, Middle, Last)*: SAMUEL GILES

18. Mother's Name *(First, Middle, Maiden Surname)*: FLORENCE GREEN

19a. Informant's Name/Relationship *(Type, Print)*: CYNTHIA PITT

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2215 WILLIAMS DR. HAVRE DE GRACE, MD 21078

20a. Method of Disposition: 1☒ Burial 2☐ Cramation 3☐ Removal from State 4☐ Donation 5☐ Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: MT. CALVARY CEMETERY

Data: 1/18/97

20c. Location - City or Town, State: ABERDEEN, MD

21. Signature of Funeral Service Licensee: Mary R. [illegible]

22. Name and Address of Facility: BEARD FUNERAL HOME 552 LEWIS ST. HAVRE DE GRACE, MD 21078

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. congestive heart failure
Due to (or as a consequence of):
b. Insulin dependent diabetes mellitus

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last
Due to (or as a consequence of):
c. Questionable pulmonary embolism
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.
hypertension
Diabetic Nephropathy

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☒ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of ceusa of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA

26. Place of Death *(Check only one)*
Other: 4☐ Nursing Home 5☐ Residence 6☐ Other *(Specify)*

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*
1☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and title of certifier: [illegible]

29c. License number: D41e412 exp 9/30/97

29d. Date signed *(Month, Day, Year)*: 1/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): [illegible] 315 S. Union Ave Havre De Grace MD 21078

State Registrar

31. Date filed *(Month, Day, Year)*: JUL 16 1998

Registrar's Signature: [illegible]

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

97 41541

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): E'Lexus Michell Middleton			2. DATE OF DEATH (Month, Day, Year): 12 / 26 / 97	3. TIME OF DEATH: 3:10 M
4. SOCIAL SECURITY NUMBER: None	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS 2 / MIN. 12	7. DATE OF BIRTH (Month, Day, Year): 122697	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Prince Georges Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly	9c. COUNTY OF DEATH: Prince Georges		

RESIDENCE OF DECEDENT

10a. STATE: md.	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Landover	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3111 Bright Seat Road	10f. ZIP CODE: 20785	10g. CITIZEN OF WHAT COUNTRY? US	

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Infant; College (1-4 or 5+): Infant	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Infant	16b. KIND OF BUSINESS/INDUSTRY: Infant	
17. FATHER'S NAME (First, Middle, Last): Alan Deon Walton	18. MOTHER'S NAME (First, Middle, Maiden Surname): Timeka Diana middleton		
19a. INFORMANT'S NAME (Type/Print): Timeka middleton	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3111 Bright Seat Rd Landover md 20785		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): MEDEX — DATE: 5398	20c. LOCATION — City or Town, State: HAMLET NC	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph Richard	22. NAME AND ADDRESS OF FACILITY: [illegible]		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory failure / Cardiac failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Non Immune hydrops.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28d. DESCRIBE HOW INJURY OCCURED	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mehmet Ozcelik	29c. LICENSE NUMBER: D28189	29d. DATE SIGNED (Month, Day, Year) ▶ 7/20/98
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): c/o P.G HOSPITAL		
31. DATE FILED (Month, Day, Year): JUL 30 1998	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41542

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Frances Louise Oleary
2. Date of Death: Month August Day 15 Year 1997
3. Time of Death: 2310pm
4a. Facility Name (If not institution, give street and number): SHADY GROVE ADVENTIST HOSPITAL
4b. City, Town, or Location of Death: ROCKVILLE
4c. County of Death: MONTGOMERY

Funeral Director

5. Social Security Number: 121-26-1470
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 64 Yrs.
If Under 1 Year: Months / Days
If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): June 19, 1933
9. Birthplace (State or Foreign Country): New York

Usual Residence of Decedent

10a. State: Maryland
10b. County: Montgomery
10c. City, Town or Location: Potomac
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 14005 North Common Way
10f. Zip Code: 20854
10g. Citizen of What Country?: United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): / College (1-4or 5+): 1
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker
16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Vincent Maher
18. Mother's Name (First, Middle, Maiden Surname): Monica Gallagher

19a. Informant's Name/Relationship (Type, Print): John H. O'Leary/ Husband
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14005 North Common Way Potomac, Maryland 20854

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
Date: August 20, 1997
20c. Location - City or Town, State: Valhalla, New York

21. Signature of Funeral Service Licensee: ▶ [signature] M00335
22. Name and Address of Facility: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Subarachnoid cerebral hemorrhage — 13 days
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ Nathan Moskowitz, M.D.
29c. License number: D32683
29d. Date signed (Month, Day, Year): August, 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Nathan Moskowitz, M.D. 14812 Physicians Lane Rockville, Maryland 20850

State Registrar

31. Date filed (Month, Day, Year): AUG 20 1997
32. Registrar's Signature: Julia Davidson Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

See Reverse G769 3/31/99 EW

Certificate of Death

Reg. No. 97 41543

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Raymond Thomas Wolfe Sr.

2. Date of Death: Month Jan. Day 19, Year 1997

3. Time of Death: 2:30 PM

4a. Facility Name (If not institution, give street and number): 3976B Wistman Lane

4b. City, Town, or Location of Death: Myersville

4c. County of Death: Frederick

Funeral Director

5. Social Security Number: 215-14-8140

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 74 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Apr. 16, 1922

9. Birthplace (State or Foreign Country): MD.

Usual Residence of Decedent

10a. State: MD.

10b. County: Frederick

10c. City, Town or Location: Myersville

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 3976B Wistman Lane

10f. Zip Code: 21773

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): carpenter

16b. Kind of Business/Industry: self-employed

17. Father's Name (First, Middle, Last): Albert Wolfe

18. Mother's Name (First, Middle, Maiden Surname): Ida Winfield

19a. Informant's Name/Relationship (Type, Print): Mildred F. Wolfe(Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3976B Wistman Lane, Myersville, Md. 21773

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Harmony Cemetery

Date: 1/22

20c. Location - City or Town, State: Myersville, Md.

21. Signature of Funeral Service Licensee: Donald B. Thompson

22. Name and Address of Facility: Donald B. Thompson Funeral Home, 31 E. Main St., Middletown, Md. 21769

To Be Completed by Funeral Director

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)	a. Cardiac Arrest	mins
Due to (or as a consequence of):	b. Congestive Heart Failure	2wks
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Colon Ca c Liver Lung Metastases	months
Due to (or as a consequence of):	d.	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: diabetes mellitus

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [X] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | Other: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury: M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles R Wiener MD

29c. License number: D-13291

29d. Date signed (Month, Day, Year): Jan 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 417 Main St, Myersville Md 21773

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar

31. Date filed (Month, Day, Year): MAR 30 1999

32. Registrar's Signature: Jenna B. Sparks

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Filed Late 3/30/99 Verified by Cemetery per GS

Remains not found:
Court order issued by
Judge Roger W. Brown
Circuit Court for Baltimore City
Case # 198118022,24,26,28

Court Ordered Death,FilmG776 10/27/99 kam per M.E.'s Office

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97-41544

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Derrick Cartess Briggs
2. Date of Death: Month March, Day 09, Year 1997
3. Time of Death:
4a. Facility Name (If not institution, give street and number): Baltimore City Court Order
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 218-84-2921
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 28 Yrs. | If Under 1 Year: Months, Days | If Under 24 Hrs.: Hours, Min.
8. Date of Birth (Month, Day, Year): 10-11-68
9. Birthplace (State or Foreign Country): MD

Usual Residence of Decedent

10a. State: MD
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 1309 Poplar Grove Street
10f. Zip Code: 21216
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Porter
16b. Kind of Business/Industry: Nursing Home

17. Father's Name (First, Middle, Last): Curtis Cartess Simmons
18. Mother's Name (First, Middle, Maiden Surname): Betty Jean Briggs

19a. Informant's Name/Relationship (Type, Print): Betty Simmons
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4126 Potter St. #301 Baltimore, MD 21229

20a. Method of Disposition: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): N/A
Date: N/A
20c. Location - City or Town, State: N/A

21. Signature of Funeral Service Licensee: N/A
22. Name and Address of Facility: N/A

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Undetermined
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:
b.
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No
24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No
26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) Court Order

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. Date of Injury (Month, Day, Year): Unknown
28b. Time of Injury: Unknown M
28c. Injury at Work? 1 [ ] Yes 2 [X] No
28d. Describe how injury occurred: Unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Unknown
28f. Location (Street and Number or Rural Route Number, City or Town, State): Unknown

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: John E. Smialek
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): 10-21-1999

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): John E. Smialek - Chief M.E. 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year): OCT 27 1999
32. Registrar's Signature: Geneva B. Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

REPLACEMENT

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41545

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, Last)*: WILLIAM FREDRICK JOHNSON

2. Date of Death Month / Day / Year: July 11, 1997

3. Time of Death: 11:50pm FOUND

4a. Facility Name *(If not institution, give street and number)*: 3417 39th Place

4b. City, Town, or Location of Death: Colmar Manor

4c. County of Death: Prince George's

Funeral Director

5. Social Security Number: 577-50-9857

6. Sex: [X] 1 M 2 F

7. Age *(In yrs. last birthday)*: 60 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth *(Month, Day, Year)*: Sept. 18, 1936

9. Birthplace *(State or Foreign Country)*: Wash.D.C.

Usual Residence of Decedent

10a. State: MD

10b. County: Prince Georges

10c. City, Town or Location: Brentwood

10d. Inside City Limits: [X] 1 Yes 2 No

10e. Street and Number: 3417 39th Place

10f. Zip Code: 20722

10g. Citizen of What Country?: USA

11. Marital Status: 1 Never Married 2 Married 3 Widowed [X] 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces? [X] 1 Yes 2 No If Yes, Give Year or Dates: 56-65

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes [X] 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify: Caucasian

15. Decedent's Education *(Specify only highest grade completed)*: Elementary/Secondary (0-12): 12 / College (1-4or 5+):

16a. Decedent's Usual Occupation *(Give kind of work done during most of working life. DO NOT use retired)*: Taxicab-Dispatcher

16b. Kind of Business/Industry: Blue Bird Co.

17. Father's Name *(First, Middle, Last)*: Unknown

18. Mother's Name *(First, Middle, Maiden Surname)*: Dorothy L. Johnson

19a. Informant's Name/Relationship *(Type, Print)*: Wesley Harris Friend

19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 4035 37th St. Mt. Rainer, Md 20722

20a. Method of Disposition: 1 Burial [X] 2 Cremation 3 Removal from State 4 Donetion 5 Other *(Specify)*

20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Riverdale Park Crematory

Date: 7/24/97

20c. Location - City or Town, State: Riverdale, MD

21. Signature of Funeral Service Licensee: ▶ F. Bernard Hunt, per DVR

22. Name and Address of Facility: Hunt Funeral Home 1420 34th St. S.E., Wash., D.C. 20020

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Arteriosclerotic Cardiovascular Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably [X] 4 Unknown

24a. Was an autopsy performed? 1 Yes [X] 2 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medical examiner? [X] 1 Yes 2 No

26. Place of Death *(Check only one)*: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home [X] 5 Residence 6 Other *(Specify)*

27. Manner of Death: [X] 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined

28a. Date of Injury *(Month, Day Year)*

28b. Time of Injury M

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. *(Specify)*

28f. Location *(Street and Number or Rural Route Number, City or Town, State)*

29a. Certifier *(Check only one)*: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. [X] 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: ▶ [signature]

29c. License number: D33954

29d. Date signed *(Month, Day, Year)*: SEPTEMBER 21, 1999

30. Name and address of person who completed cause of death (Item 23e) (Type, Print): Mario F. Golle, Jr., M.D. 3001 Hospital Drive, Cheverly, MD 20785

State Registrar

31. Date filed *(Month, Day, Year)*: SEP 21 1999

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 41546

Physician /Medical Examiner

Funeral Director

1. Decedent's Name (First, Middle, Last): JOAN MARCIA STEPHENS

2. Date of Death: Month Oct Day 15 Year 1997

3. Time of Death: 0600

4a. Facility Name (If not institution, give street and number): Lorien Riverside

4b. City, Town, or Location of Death: Belcamp

4c. County of Death: Harford

5. Social Security Number: 244-52-7379

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 59 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Feb. 19, 1938

9. Birthplace (State or Foreign Country): North Carolina

Usual Residence of Decedent

10a. State: Maryland

10b. County: Harford

10c. City, Town or Location: Joppa

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 220 Kershaw Ct.

10f. Zip Code: 21085

10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Homemaker

16b. Kind of Business/Industry: Own Home

17. Father's Name (First, Middle, Last): Earl Lameul Teague

18. Mother's Name (First, Middle, Maiden Surname): Alene Fanny Guiton

19a. Informant's Name/Relationship (Type, Print): George H. Stephens - Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 220 Kershaw Ct., Joppa, Md. 21085

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Arlington National Cem. | Date: 10-22-97

20c. Location - City or Town, State: Arlington, Virginia

21. Signature of Funeral Service Licensee: Charles A. Emgeh

22. Name and Address of Facility: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. | Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)
a. Cerebrovascular disease — 7 1/4 year

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b.

Due to (or as a consequence of):
c.

Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☐ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one) — Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one): 1☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D28339

29d. Date signed (Month, Day, Year): October 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 101 E Wheel Road Bel Air MD 21015

State Registrar

31. Date filed (Month, Day, Year): OCT 17 1997

32. Registrar's Signature: Judith Thurlow Randall

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To Be Completed by Funeral Director

Stephens JOAN

5

5/546

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amend Item#23a,27 perPHYG799 9/26/01 EW

Certificate of Death

Reg. No. 97-41547

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Roscoe Lewis Jr.

2. Date of Death: Month 10 Day 30 Year 1997

3. Time of Death: 8:30 a.m.

4a. Facility Name (If not institution, give street and number): 6846 Westridge Road

4b. City, Town, or Location of Death: N/A

4c. County of Death: Baltimore Co.

Funeral Director

5. Social Security Number: 402-52-0821

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 58 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): 01-13-39

9. Birthplace (State or Foreign Country): Kentucky

Usual Residence of Decedent

10a. State: Maryland

10b. County: Baltimore Co.

10c. City, Town or Location: N/A

10d. Inside City Limits: 1 [ ] Yes 2 [X] No

10e. Street and Number: 6846 Westridge Road

10f. Zip Code: 21207

10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [X] Yes 2 [ ] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 14th | College (1-4 or 5+):

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Retired E6

16b. Kind of Business/Industry: U.S. Air Force

17. Father's Name (First, Middle, Last): Roscoe Lewis, Sr.

18. Mother's Name (First, Middle, Maiden Surname): Unknown

19a. Informant's Name/Relationship (Type, Print): Janice Murray, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6846 Westridge Road, Baltimore, Maryland 21207

20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Garrison Forest Veteran

Date: 11/4/97

20c. Location - City or Town, State: Garrison, Maryland

21. Signature of Funeral Service Licensee: [signature]

22. Name and Address of Facility: William C. Brown Community Funeral Home 1206 W. North Avenue, Baltimore, Maryland 21217

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC CARCINOMA TO BRAIN — 6 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. ALCOHOL ABUSE

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

~~ETHANOL ABUSE~~

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury M

28c. Injury at Work? 1 [ ] Yes 2 [ ] No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: [signature]

29c. License number: H 50867

29d. Date signed (Month, Day, Year): 10/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): CHERYL GARDNER, D.O. 21 CROSSROADS DR. #415 OWINGS MILLS, MD. 21117

State Registrar

31. Date filed (Month, Day, Year): SEP 26 2001

32. Registrar's Signature: [signature]

DHMH 16 Rev 6/95

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97-41548

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Gail Ray Farren

2. Date of Death Month Day Year: Feb 2, 1997

3. Time of Death: 6:00 PM

4a. Facility Name (If not institution, give street and number): 10690 Ward Road

4b. City, Town, or Location of Death: Dunkirk

4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 547-50-9894

6. Sex: 1☐ M 2☒ F

7. Age (In yrs. last birthday): 57 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): Dec 1, 1939

9. Birthplace (State or Foreign Country): California

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: Maryland

10b. County: Calvert

10c. City, Town or Location: Dunkirk

10d. Inside City Limits: 1☐ Yes 2☒ No

10e. Street and Number: 10690 Ward Road

10f. Zip Code: 20754

10g. Citizen of What Country? United States

11. Marital Status: 1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12): 12

College (1-4 or 5+): 2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Census Bureau

16b. Kind of Business/Industry: U.S. Government

17. Father's Name (First, Middle, Last): David Plant

18. Mother's Name (First, Middle, Maiden Surname): Virginia Taylor Cochran

19a. Informant's Name/Relationship (Type, Print): Walter Farren

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10690 Ward Road, Dunkirk, Maryland 20754

20a. Method of Disposition: 1☐ Burial 2☒ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Lee Crematory February 3, 1997

20c. Location - City or Town, State: Clinton, Maryland

21. Signature of Funeral Service Licensee:

22. Name and Address of Facility: Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Md 20735

Physician /Medical Examiner

23a. Part I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Lung Cancer — 19 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last:

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☐ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☐ Yes 2☒ No

24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No

26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA — Other: 4☐ Nursing Home 5☒ Residence 6☐ Other (Specify)

27. Manner of Death: 1☐ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending Investigation 6☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury: M

28c. Injury at Work? 1☐ Yes 2☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:

29c. License number: D2035 2

29d. Date signed (Month, Day, Year): 2/3/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Dr. Harvey Katzen, MD. 8926 Woodyard Road, Clinton, Maryland 20735

State Registrar

31. Date filed (Month, Day, Year): FEB 04 1997

32. Registrar's Signature:

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the Maryland Report of Fetal Death.

Send: Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a or 28d show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0020

Vital Records, P.O. Box 68760,

This original may be a duplicate, if original located please discard, dhb 02

12

VSH 16 Rev 6/95

4105355285

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97-41549

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): MABEL ISABEL KING
2. Date of Death: Month January Day 29 Year 1997
3. Time of Death: 2:45 pm
4a. Facility Name (If not institution, give street and number): 145 West Mt. Harmony Road
4b. City, Town, or Location of Death: Owings
4c. County of Death: Calvert

Funeral Director

5. Social Security Number: 216 40 6754
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): 88 Yrs. | If Under 1 Year: Months / Days | If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): Apr. 10, 1908
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: Calvert
10c. City, Town or Location: Owings
10d. Inside City Limits: 1☐ Yes 2☒ No
10e. Street and Number: 145 West Mt. Harmony Road
10f. Zip Code: 20736
10g. Citizen of What Country? USA

11. Marital Status: 1☐ Never Married 2☐ Married 3☒ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: white

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 4 | College (1-4or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): house and farm wife
16b. Kind of Business/Industry: own home & farm

17. Father's Name (First, Middle, Last): John Hall
18. Mother's Name (First, Middle, Maiden Surname): Martha Ellen Hardesty

19a. Informant's Name/Relationship (Type, Print): Alma K. Ford / daughter
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 143 West Mt. Harmony Road, Owings, MD 20736

20a. Method of Disposition: 1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Mt. Harmony Church Cemetery | Date: 2/2/97
20c. Location - City or Town, State: Owings, MD

21. Signature of Funeral Service Licensee: ▶ William R. Jones
22. Name and Address of Facility: Rausch Funeral Home, P.A., Owings, MD 20736

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (Approximate Interval Between Onset and Death)

Immediate Cause (Final disease or condition resulting in death): a. Heart Failure
Due to (or as a consequence of): b. Aortic Stenosis
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
Due to (or as a consequence of): c.
Due to (or as a consequence of): d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Osteoarthritis
Hypertension

23b. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown
24a. Was an autopsy performed? 1☐ Yes 2☑ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☐ No

25. Was case referred to medical examiner? 1☐ Yes 2☑ No
26. Place of Death (Check only one): Hospital: 1☐ Inpatient 2☐ ER/Outpatient 3☐ DOA | Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)
27. Manner of Death: 1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: ▶ [signature]
29c. License number: D45235
29d. Date signed (Month, Day, Year): 1/31/97
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): 19E. Chesapeake Beach Rd. Owings, MD 20736

State Registrar

31. Date filed (Month, Day, Year): JAN 31 1997
32. Registrar's Signature: ▶ Julia Davidson-Randall

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified as soon

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that this death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar

Certificate of Death

Reg. No. 1997-41550

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Shirine Leslie Farajali
2. Date of Death: Month 11 Day 04 Year 1997
3. Time of Death: 6:43 P.M
4a. Facility Name (If not institution, give street and number): Johns Hopkins Hospital
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death:

Funeral Director

5. Social Security Number: Infant
6. Sex: 1☐ M 2☒ F
7. Age (In yrs. last birthday): Yrs.
If Under 1 Year: Months; Days 3
If Under 24 Hrs.: Hours 7; Min.
8. Date of Birth (Month, Day, Year): 11 04 1997
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1☒ Yes 2☐ No
10e. Street and Number: 2225 East Baltimore Street
10f. Zip Code: 21231
10g. Citizen of What Country? USA

11. Marital Status: 1☒ Never Married 2☐ Married 3☐ Widowed 4☐ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1☐ Yes 2☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1☐ Yes 2☒ No Specify:
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)
Elementary/Secondary (0-12): 0
College (1-4or 5+): N/A
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Infant
16b. Kind of Business/Industry: Infant

17. Father's Name (First, Middle, Last): Faraydoon Farajali
18. Mother's Name (First, Middle, Maiden Surname): Denise Link

19a. Informant's Name/Relationship (Type, Print): Denise Link-Farajali / Mother
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2225 East Baltimore Street Baltimore, MD 21231

20a. Method of Disposition: 1☐ Burial 2☐ Cremation 3☐ Removal from State 4☒ Donation 5☐ Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Johns Hopkins Hospital
Date: November 7, 1997
20c. Location - City or Town, State: Baltimore, Maryland

21. Signature of Funeral Service Licensee: Kenneth Boston
22. Name and Address of Facility: Johns Hopkins Hospital 600 North Wolfe Street Baltimore, MD 21287

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)
e. Complex Congenital Heart Disease — Approximate Interval Between Onset and Death: 3d

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
b. Due to (or as a consequence of): Trisomy 18 — 3d
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1☐ Yes 2☒ No 9☐ Unknown
23c. If yes, outcome of pregnancy: 1☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy 4☐ Pregnant at time of death 5☐ Other (specify) 9☐ Unknown
23d. Date of delivery: Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1☐ Yes 2☒ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed? 1☒ Yes 2☐ No
24b. Were autopsy findings available prior to completion of cause of death? 1☐ Yes 2☒ No

25. Was case referred to medical examiner? 1☐ Yes 2☒ No
26. Place of Death (Check only one): Hospital: 1☒ Inpatient 2☐ ER/Outpatient 3☐ DOA Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify)

27. Manner of Death: 1☒ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Pending investigation 6☐ Could not be determined
28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1☐ Yes 2☐ No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
29b. Signature and title of certifier: Edward E. Lawson
29c. License number: D0054309
29d. Date signed (Month, Day, Year): APRIL 13, 2006
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Edward E. Lawson, MD Johns Hopkins Hospital 600 N. Wolfe St Baltimore MD 21287

State Registrar

31. Date filed (Month, Day, Year): APR 25 2006
32. Registrar's Signature: Karen L. Sparks

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

DHMH 17 Rev 1/2001

ORIGINAL

06-07280
Toni Dee Vogel-Kirby

Remains not recovered. Court ordered by Case #24-C-06-003117, Edward R.K. Hargadon, Judge

Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. A97-41551

Physician/ Medical Examiner

1. Decedent's Name (First, Middle,Lest): Toni Dee Vogel-Kirby
2. Date of Death Month Day Year: May 21, 1997
3. Time of Death: 0000 hrs
4a. Facility Name (if not institution, give street and number): Court Ordered
4b. City, Town, or Location of Death: Baltimore City
4c. County of Death: N/A

Funeral Director

5. Social Security Number: 216-78-2722
6. Sex: 1 ☐ M 2 ☒ F
7. Age (In yrs. last birthday): 29 Yrs
If Under 1 Year: Months / Days
If Under 24Hrs.: Hours / Min.
8. Date of Birth(MM/DD/YYYY): 06/23/1967
9. Birthplace (State or Foreign Country): Maryland

Usual Residence of Decedent

10a. State: Maryland
10b. County: N/A
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 ☐ Yes 2 ☒ No
10e. Street and Number: 236 S. Mount Street
10f. Zip Code: 21223
10g. Citizen of What Country?: USA

11. Marital Status: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:
13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc) 1 ☐ Yes 2 ☒ No specify
14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Sales
16b. Kind of Business/Industry: Department Store

17. Father's Name (First, Middle, Lest): Edward D. Vogel
18. Mother's Name (First, Middle, Maiden Surname): Helen Margaret Phillips

19a. Informant's Name/Relationship (Type, Print): Helen Margaret Vogel
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4213 Ritchie Highway, Baltimore, Maryland 21225

20a. Method of Disposition: 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other Specify:
20b. Place of Disposition (Name of cemetery, crematory or other place):
Date:
20c. Location - City or Town, State:

21. Signature of Funeral Service Licensee:
22. Name and Address of Facility:

Physician /Medical Examiner

23a. Part I. Enter the diseese, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest, shock, or heert failure. List only one cause on each line. — Approximate Intervel Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. Undetermined
Due to (or as a consequence of):
Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last
b.
Due to (or es a consequence of):
c.
Due to (or as a consequence of):
d.

☐ UNPENDED ☐ AMENDED

IF FEMALE.
23b. Wes decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown
23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant et time of death 5 ☐ Other (Specify) 9 ☐ Unknown
23d. Date of delivery Month Dey Yeer

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

24a. Wes an eutopsy performed? 1 ☐ Yes 2 ☑ No
24b. Were autopsy findings available prior to completion of ceuse of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No
26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other Scene

27. Manner of Death: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☑ Could not be determined
28a. Date of Injury (Month, Day,Year): Unknown
28b. Time of Injury: Unknown
28c. Injury at Work? 1 ☐ Yes 2 ☐ No Unknown X
28d. Describe how injury occurred: Unknown
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify): Other (specify)
28f. Location (Street and Number or Rurel Route Number, City or Town, State): Unknown, Unknown,

29a. Certifier (Check only one): 1 ☐ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and menner as started
2 ☑ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier: J. M. Titus
29c. License number: O.C.M.E.
29d. Date signed (Month, Day, Year): September 27, 2006

30. Name and address of person who completed ceuse of death (Item 23a): Jack Titus MD. - Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed (Month, Day, Year): SEP 29 2006
32. Registrar's Signature: Eleanor B. Speller

Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760, **To the Hospital or Attending Physician:** The law requires that the death certificate be executed within 24 hours after death. **To the Funeral Director:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

DHMH 17 Rev 1/2001
OCME 2006

ORIGINAL